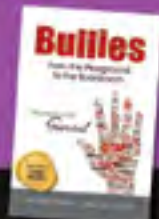




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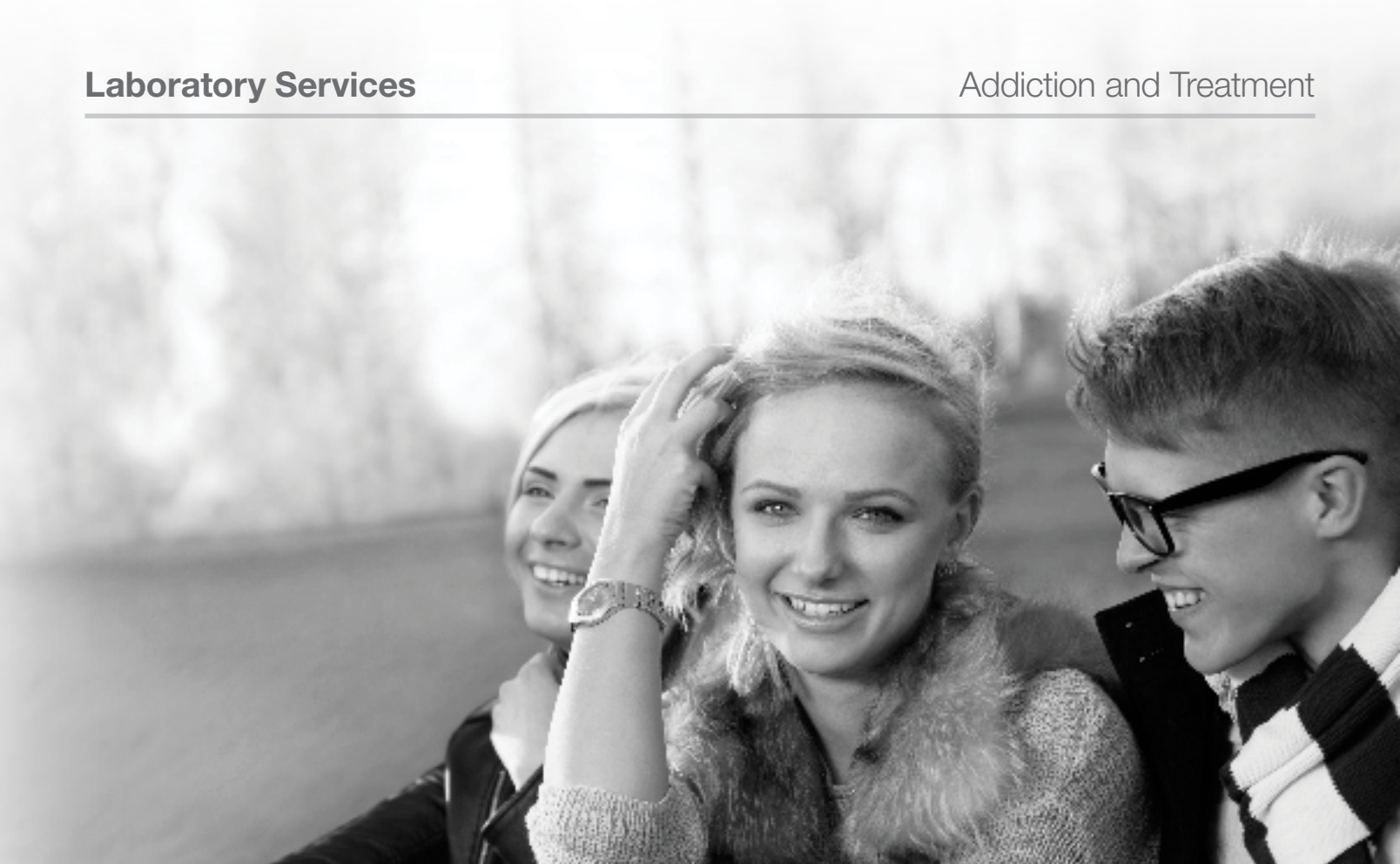
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Announcing . . . The NEW *Counselor Connection* Newsletter

Counselor magazine's digital newsletter, *Counselor Connection*, will feature a brand new layout, new content, and a new schedule starting fall of 2014!

The new version of *Counselor Connection* will be sent out biweekly instead of bimonthly, in order to provide subscribers with even more up-to-date information, feature articles, and book reviews.

The new *Counselor Connection* will feature all new columns . . .

- "Industry Issues," written by *Counselor* Editor Robert J. Ackerman, PhD
- "Counseling Skills," written by author and speaker Dennis C. Daley, PhD
- "Experiential Treatment," written by author Tian Dayton, PhD
- "Clinical Supervision," written by John Fulan, LMFT

. . . as well as new sections that will benefit all addiction and behavioral health professionals.

- "Announcements," which will feature relevant happenings in the addiction and behavioral health field
- "Resources for the Counselor," which will provide reviews and information about documentaries, books, training manuals, movies, and other important media
- "The Conference Report," which will provide information on upcoming and past conferences
- "Recovery Voices," where readers can share their own stories of addiction and recovery

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Let's Go to a Conference!



During this past year I attended several state summer schools and conferences on behavioral health, mental health, and alcohol and drug addiction. In most cases I attended as a speaker and enjoyed meeting the many attendees. Although I have been presenting for many years, I still look forward to conferences. I find them very energizing for myself and for the participants. Conferences offer the opportunity to break our daily routines, the opportunity to connect with other clinical professionals, and the opportunity not to be the expert for other people for a few brief days. In short I believe attending a conference is a good way to handle burnout.

Presentation topics at these conferences range from new information about old and continuing problems to new scientific discoveries about human behavior and improving clinical techniques. Sometimes I am asked to present on a topic that I did years ago only to realize that these topics are now being heard by an entirely new audience who is hearing the information for the first time. At the same time, I must constantly update my presentations for today's issues. I find that those attendees who get the most out of a conference are those who come as professionals and leave as consumers. A good conference has something that each person can identify with personally as well as professionally. I hope you have the opportunity to attend a conference soon; it will be good for you!

In this edition of *Counselor* we offer our first in a series of information on process additions. As you know, process

addictions share many similarities to alcohol and drug addiction without the alcohol and drug abuse or in combination with them. Behaviors such as compulsive gambling, sex addiction, Internet addiction, and work addiction are all examples of process addictions. Many of the interventions utilized to treat substance abuse lend themselves to the treatment of process addictions. Obviously, the types and kinds of addictions we are facing today are increasing as well as the necessity to learn about them and to develop successful treatment outcomes. We begin our series on process addictions with an overview and with feature articles on problem gambling and food addiction. Additionally, this issue will also offer you a brand new national directory focusing on process addictions and eating disorders.

Finally, I would like to inform you that October is National Bullying Prevention Month. We will take part in raising awareness through our "Inside Books" column, which will feature *Bullies: From the Playground to the Boardroom*.

I hope you enjoy this issue of *Counselor*.

Robert J. Ackerman, PhD

A handwritten signature in black ink that reads "Robert J. Ackerman".

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Make the Rule to Break the Rule: Setting Your Ethical Standards

Jennifer D. Berton, PhD, LICSW, CADC II



Let's play a game! I'll present you with some short ethical scenarios and you think about what you would do in each situation. Sound fun? Good. Okay, here we go . . .

- J. L. is your client in an outpatient agency, who presents you with a meaningful gift to thank you for "saving his life." Do you accept the gift?

- S. B. is a client in the agency where you work. While driving to work one day, you spot her on the side of the road, walking to the agency. The weather is terrible outside. Do you transport her to the agency?
- C. R. is a client in one of your early recovery groups. During group, he asks if you are in recovery too. Do you answer his question?

Now, were any of your answers to any of these questions "it depends?" When I give ethics trainings, the resounding majority of participants consistently say "it depends," so I'm going to assume that the majority of you readers also gave this common answer.

What if I told you it isn't a very good answer, or at least not a very ethical one? I can hear the loud protests! I know, I know, we are taught

to treat each client as the wonderfully unique beings they are, which would support the idea that how you treat a person in each of these scenarios will depend on the specific situation. You might look at J. L. and say it depends on whether it is a graduation gift, or whether he is from a certain culture that places great value in gift-giving. You might look at S. B. and say it depends on whether she can be trusted

in your vehicle, or whether she can be trusted not to behave inappropriately. You should be including your geographical weather patterns in your decision making. For example, if you live in North Carolina and you are driving through a blizzard, it is more likely to be an exception that would compel you to rescue S. B. However, if you are driving through a blizzard in Minnesota, it is certainly not an exception and you should have a rule in place for that scenario. You might consider C. R. and say it depends on whether the self-disclosure will clinically benefit him, or what damage you predict withholding disclosure will have on C. R.'s mental health.

In each of these situations, you can see there are many reasons—many more than are listed here—for giving “it depends” as the answer. So what is the problem here? If you are honoring the unique individual and set of circumstances that brought him or her to your office, “it depends” is a logical answer to any clinical scenario, isn't it? Anyone detect the problem with this thinking?

It's true that every person sitting in your office is unique and will bring in a special set of thoughts, beliefs, experiences, and circumstances that will present a diagnostic puzzle and will demand creative treatment planning. Yet the need for clinical flexibility in assessing and treating your clients does not replace the equally vital requirement for ethical standards in your daily practice. In fact, the profession relies on it.

In protecting the client, our ethical standards

are based on the four ethical pillars: justice, beneficence, autonomy, and nonmaleficence (Berton, 2014; Castillo & Waldorf, 2008; Corey, Corey, & Callanan, 2007; Miller, 2008; Roberts & Geppert, 2008; Taleff, 2009; Venner & Bogenschutz, 2008). We ensure that the client is treated fairly (justice), that our actions serve to make the client better (beneficence), that a goal of our treatment is to promote client independence and participation (autonomy), and that overall we strive to avoid doing harm to the client (nonmaleficence). Looking at these constructs, the “it depends” response to ethical dilemmas seems an ethically healthy choice for two pillars, questionable with one pillar, and a poor response for one. Any guesses?

Well, treating every scenario as a unique situation with a unique response helps us honor nonmaleficence and beneficence by focusing on promoting wellness and avoiding harm in each individual case.

Autonomy is a bit trickier. In any of the aforementioned scenarios, you might tell me that you would direct your course of action based on the mental health of the client. For example, you may feel compelled to accept J. L.'s gift because he is healthy enough to understand the ethical boundaries of gift giving. Or perhaps you agree to go on a date with one of your clients because surely he or she can maintain the boundaries necessary to keep the therapeutic relationship intact. Anyone detect a problem with this thinking? How can you be sure your

assessment of your client's thinking and ability for boundary control is correct? Unless you share a brain, your assessment is subjective and you can be wrong, or can mistake your own ability with that of your clients. The only brain on which you should rely is your own, and let's face it, you can be swindled by your own brain at times.

Sometimes we are certain of how we think or feel about a situation, until a friend or therapist suggests an alternative, and we realize that is how we truly feel. If we can be mistaken about how we feel, we can certainly be dead wrong about other people's thoughts, feelings, and motivations. Thus, we can't regularly make decisions based on the individual brain sitting before us; we can only regularly make decisions based on the brain inside us. Relying on your own brain allows for you to make a rule. You

can decide how you operate in the majority of situations because your thoughts and feelings should not deviate significantly in most common situations.

The pillar of justice conflicts with the “it depends” response. Treating clients fairly as you would treat other clients helps direct us to create standards by which we can judge the pillar of justice. If we treat every client individually without a standard as a guideline, we can't uphold the pillar of justice. The idea of fair treatment cannot be measured without a determined standard of care. This should give us pause. The task of protecting the client can benefit from creating a standard, but what of the task of protecting the clinician and the profession at large?

The clinician can be protected by having a set of guidelines that ensure an



ethical practice, both those enforced through a written code and those created by the clinician. Rules are a blueprint that can ensure the clinician is supported in the choices they make, as long as they follow the guidelines and avoid going rogue. If anyone is questioning your ethical behavior, you can point to the standard to bolster your reasoning. As a group, if we are good at putting our client's needs first, that indicates we aren't putting our own needs at the forefront, but are squashing them down behind those of the folks we serve. The problem with this is that while we may ensure our individual clients are treated well, we can simultaneously put our careers at risk.

Integrity doesn't come from how we treat one person, but from evaluating our performance as a whole. The little individual decisions you make are part of a larger trend across clients, across jobs. Ethical clinicians will show consistency in their whole performance; the standards and rules by which they inform their practice will be clear when evaluating their work. Thus, making rules about our standard way of operating is a superior choice to the "it depends" option when protecting ourselves.

This leaves us to discuss the profession at large. A profession is an entity that relies on its members to survive, so the profession only functions when you and I do our jobs well. If we don't make sound ethical decisions, the profession takes a hit. We tend not to think in these global terms, perhaps because the profession isn't as tangible



as a person, yet if we don't protect it, who will? Thus, the concern with failing to make a rule, with using "it depends" as a sound ethical answer, is not so much that you are using "it depends" in your practice, but that we are all using "it depends" as our regular ethical answer. We are using "it depends" so often that the exceptions have become the rule (Berton, 2014; Taleff, 2009).

Think about this. The very definition of a profession requires that we have a communicable set of standards or code of conduct (Berton, 2014; Brown, 1992; Jackson, 2010; Larson, 1977). If our exceptions become the norm, we no longer have a standard of care, and we will no longer meet the criteria of a profession. Take that thought with you the next time you are in front of an individual, pondering the most ethical course of treatment. You want to consider the best action that will protect your client's needs, but you also want to ask yourself: What is the best action to protect the profession and myself?

You must first decide the rule before you make an exception. Make the rule before you break the rule.

Exceptions to any rule we set will absolutely occur. However, if you can state, "My policy is _____, but this situation is an exception because _____," you will ensure the exceptions remain true exceptions rather than becoming the rule. If you can do this, you will be protecting the client, the clinician, and the profession. That trifecta of ethical benefit is a win-win . . . win. **C**

Jennifer Berton, PhD, LICSW, CADC II, is the author of *Ethics for Addiction Professionals* and maintains the blog, *clinicalethicsblog.com*. Dr. Berton

has worked in a variety of inpatient and outpatient settings, and currently has a private practice of psychotherapy, supervision, and consultation. She previously served as chair of the Ethics Committee for the California Association of Alcohol and Drug Abuse Counselors (CAADAC), where she continues to serve as a consultant.

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The Value of Credentialing

Mary Jo Mather

Substance abuse is so widespread and costly to society that the credentialing of professionals who work in the field is critically important. Quality care requires a competent workforce that is well-trained, educated, and skilled in providing appropriate services to clients. It is the position of IC&RC that regulatory and funding agencies—whether on the national or local level—should require that prevention, substance use treatment, and recovery professionals be certified in order to ensure services are provided in an appropriate and ethical manner.

In recent years, several state legislatures have considered licensure of substance use treatment professionals, and there has been confusion about the difference between certification and licensure. The two are different, and this article will explain how.

Licensure

A license is a state's grant of legal authority to practice a profession within a designated scope of practice. It is required in order to practice or to call oneself a licensed professional. Some states have a single license and some have a two-tiered system, and the names of licenses, as well as requirements, vary from state to state. Licensing can also be thought of as mandatory certification. Under a licensure system, states define by statute the tasks and function or scope of practice of a profession and provide that these tasks may be legally performed only by those who are licensed.

The majority, if not all, of US states require individuals to meet a set of minimum standards of practice to work as a substance use disorder counselor or clinical supervisor. These requirements

are in place because substance use disorder counselors and clinical supervisors have a unique relationship with their clients. Substance use disorder clients bring multiple health, economic, and family concerns into the treatment setting, requiring counselors—and by extension their clinical supervisors—to address many personal and confidential issues. Without demonstrated practice competencies and adherence to a code of professional ethics, such relationships have the potential to become harmful or inappropriate.

Certification

A certification is typically a voluntary process, although it can be required to practice in certain states. Certification is often provided by a private organization for the purpose of providing the public protection on those individuals who have successfully met all requirements for the credential and demonstrated their ability to perform their profession competently. It represents the achievement of a level of professional competency agreed upon by the international community as qualified to practice effectively. In some states, holding a certification can help a professional obtain a license. IC&RC certification can also allow a professional to more easily relocate to another IC&RC state or jurisdiction. Like a license, certification requirements can and do vary from state to state, but IC&RC ensures that its boards adhere to a set of minimum standards of competency.

Regulators and community treatment agencies have long required substance use disorder treatment professionals to hold a professional certification. With the advance of managed health care over the past several years, many

governments have now adopted standards that parallel certification requirements for substance use disorder practitioners.

Complementary Processes

Ideally, licensing and certification processes can coexist in a single jurisdiction and complement one another. One example of this is when a state recognizes the existing credentialing organization that provides a stringent, legally defensible, reliable, and valid credentialing process. The state licensing entity contracts with the credentialing board to administer the credential and the examination. Once a candidate completes the credentialing process, the certification board transfers that information to the licensing entity who then issues the license. The licensing standards match the certification standards, and the license is predicated on the professional first obtaining the certification and passing the examination followed by the issuance of the license by the state licensing entity. Synchronizing the certification process and licensing process provides the ultimate in public protection and reduces cost to the state government. 

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Fatal Attraction: Celebrity Stalkers Who Kill

Maxim W. Furek, MA, CADC, ICADC

A genre of films has entered into the domain of the stalker with offerings such as *Play Misty for Me*, *Single White Female*, *The Crush*, *Misery*, *Raising Cain*, and the highly successful *Fatal Attraction*. These films satiate our curiosity with themes of fantasy and dangerous obsession, but do they ultimately present true quantifiable realism or crass exploitation of an illness?

There have been numerous attempts to define the stalker. Meloy has proposed that stalking is “the willful, malicious, and repeated following and harassing of another person” (1998) while Zona and colleagues have delineated three types of stalkers: simple obsessional, erotomania, and love obsessional (Zona, Sharma, & Lane, 1993). Kulbarsh suggests that

the typical profile of delusional stalkers is that of a single, socially immature loner, who has been unable to establish or sustain close relationships with others. Delusional stalkers rarely date and have had few, if any, sexual relationships. They usually come from an emotionally barren or severely abusive childhood; growing up to have a very poor sense of their own identities. Most delusional stalkers have a predisposition toward psychosis.

The common victim of the delusional stalker is most frequently a person of a higher socioeconomic class/status who has had little, if any, previous contact with the stalker (Kulbarsh, 2007).

John Moore contributed to the research with his obsessive love wheel. Moore attempted to demonstrate the obsessive relational progression (ORP), a specific style of attachment disorder driven by a fear of abandonment, noted with relationally dependent individuals.



The four phases of ORP are as follows (Moore, 2009):

- The attraction phase, characterized by an instantaneous and overwhelming attraction to another person
- The anxious phase, when the afflicted individual creates the illusion of intimacy, regardless of the other person's true feelings
- The obsessive phase, usually where the person being controlled begins to withdraw and sever the relationship
- The destructive phase, the most dangerous phase where anger, rage, and a desire to seek revenge are observed

Desperate Inference

Moore's destructive phase was evidenced after “spree killer” Andrew Phillip Cunanan went on his bloody rampage. During a three-month period, Cunanan, age twenty-seven, murdered at least five people, including fashion designer and “gay icon,” Gianni Versace. Unable to respect the autonomy of his

idol, a desperate inference of envy, rage, and homicide unfolded. Versace, age fifty, was shot dead on July 15, 1997, on the steps of his Miami Beach mansion as he returned from a morning walk. With an angry pull of the trigger, Cunanan took it all away. Adding to his notoriety, Cunanan was listed on the Federal Bureau of Investigation's (FBI) fugitive report. The killing spree ended with Cunanan's suicide eight days later, using the same gun that killed Versace.

In the aftermath, the media attempted to make the killer into something he was not. Cunanan, who lived “a relatively dull existence,” was a little-known multiple murderer who, after killing Versace, received immediate infamy and was titillatingly described as a “spree killer,” “diabolic icon,” and representative of the worst fears hidden within the gay community (Poniewozik, 1999). He was none of these things, but

was in fact a drugstore clerk who lived with his mother and fantasized about a life of money and glamour. Getting, then losing, a taste of that life through a relationship with a wealthy older man . . . Cunanan entered a spiral of

debt and jealousy that led disastrously and clumsily to a string of murders (Poniewozik, 1999).

Examination of Cunanan's behavior in *The Anatomy of Motive* "indicated that he may have suffered from psychopathy, a personality disorder characterized by an abnormal lack of empathy" (Douglas & Olshaker, 1999). Like other stalkers, Cunanan

set out to destroy the object he most admired, that he most coveted. In doing so, and, in his own mind, he accomplished something of note.

The stalker and the nonpolitical assassin are obsessed with the object of their attention and/or what they represent. In some cases, as with Mark David Chapman, killer of John Lennon, they out-and-out want to be that person. And when they can't, they decide that no one else can be, either . . . And like Chapman with Lennon, John Hinckley with his actress idol Jodie Foster, and other stalkers, there was a part of Cunanan that wanted to be forever linked to his target, and so he shall be (Douglas & Olshaker, 1999).

Star Burned Brighter

Therapist Hank Houston believes celebrity stalkers

may be trying to find an identity through contact with celebrities, in an attempt to bring interest to their otherwise lackluster existence. As the stalking process continues the stalker may, in his/her own mind, develop a closer relationship with the celebrity. If the stalker cannot continue to strengthen this relationship they may feel a sense of rejection by the celebrity and, consequently, become angry. The stalker may want to denigrate the celebrities' importance by causing physical, emotional or financial injury (M. Furek, personal communication, September 21, 2012).

One such example was the delusional individual who murdered John Lennon. Mark David Chapman, a twenty-three-year-old former security guard, traveled to New York City from Hawaii to assassinate the forty-year-old singer.

The ex-Beatles' murder was as much a matter of chance as it was of celebrity. Chapman had considered targeting celebrities including Ronald Reagan, Jacqueline Onassis, David Bowie, Johnny Carson, Elizabeth Taylor, and George C. Scott, but decided to murder Lennon because, as Chapman rationalized, "his star burned brighter than the others" and "If he was less famous than three or four other people on the list, he would not have been shot" (McLaughlin, 2012).

Chapman spent the afternoon of December 8, 1980, outside the Dakota, the Manhattan apartment building where the singer and political activist lived with his family. There, Chapman carried the *Double Fantasy* album that he had the former Beatle autograph.

Hours later, at 10:50 PM, according to Biography.com:

Husband and wife return home in their limo. After exiting the vehicle, Lennon makes eye contact with the awkward young man he'd met hours earlier: Chapman, with his now-signed album in hand, is after more than an autograph this time, however. Seconds later, Chapman pulls out a .38 handgun and fires five shots at the musician, hitting Lennon four times—in the back and the chest. Lennon somehow manages to continue walking, eventually collapsing in the front vestibule of the Dakota; strewn around him are a number of cassettes that he'd been holding.

A terrified Yoko Ono enters the Dakota screaming, "John's been shot!" Seconds later, building worker Jay Hastings alerts the police. Officer Steve Spiro arrives at the scene within minutes and Lennon is taken to Roosevelt Hospital, near Central Park on 59th Street (Nash, 2013).

The shooter remained on the scene. He casually read passages from *A Catcher in the Rye* as Lennon lay dying.

Chapman pleaded guilty to second-degree murder and was sentenced in 1981 to twenty years to life. He was incarcerated at Wende Correctional Facility in Alden, New York (Virtanen, 2012). In 1981, over a period of three months, Chapman mailed four typed

letters to former New York Police Department Officer Stephen Spiro. Chapman asked Spiro to read *Catcher in the Rye*, hinting that the novel could explain what led to the rock icon's murder. Chapman suffered the delusion that he was like Holden Caulfield, the fictional character in the 1951 book. In the story, Caulfield is a bright yet naive young man who is expelled from preparatory school and decides to go to New York City. The novel dealt with teenage rebellion, belonging, and alienation—all difficult themes for Chapman.

Chapman referred to Lennon as "a phony," an apparent reference to Caulfield, the troubled narrator of J. D. Salinger's book. "I will let you decide whether Mr. Lennon was a phony or not. His words shoot his life-purpose full of holes," the murderer wrote. "Yes, Lennon was a phony of highest degree but there were others who could—and would—have served the same purpose. I believe the District Attorney has these names" (Roberts, 2013).

As detailed in *The Lives of John Lennon*,

After Chapman had been examined by no fewer than nine psychiatrists and psychologists, the consensus was that he was suffering from pathological narcissism, characterized by a "grandiose sense of self-importance, fantasies of success, power, and ideal love, indifference to the feelings of others, a need for constant attention and admiration, feelings of rage, shame, humiliation, and inferiority in response to criticism and entitlement to special favors" plus a "proneness to manipulate suicidal gestures" (Goldman, 1988).

Chapman was denied release from prison during his seventh appearance before the three-member New York corrections parole board. Transcripts revealed chilling details about his preparation for the assassination. He acquired "more deadly" hollow-point bullets from a friend who was a deputy sheriff in Atlanta. He flew from Hawaii to New York City twice to case the Dakota apartment building. Chapman confessed, "I'm so bonded that I could probably assure you that, if released,

I'd probably stay right where I'm at. You know, once you stand on a rock for twenty years and feel the waves on you and you don't go anywhere because you're on a rock, you don't want to move" (McLaughlin, 2012).

Taxi Driver

Psychotic and delusional stalkers are dangerous. Unable to separate fantasy from reality, they view their target as objects of obsession. In many instances they become homicidal after misguided attempts at affection, intimidation, and control are thwarted.

John Hinckley Jr. was fixated upon fourteen-year-old actress Jodie Foster. He obsessively watched *Taxi Driver* on a continuous loop. Around 1980, he relocated to New Haven, Connecticut, after Foster decided to take a break from Hollywood and enroll at Yale. Hinckley enrolled at the same university for the sole purpose of developing a relationship with her. He began to slip poems under Foster's door. Eerily, he also left letters in her mailbox, including one, in an effort to win her affection, where he outlined plans to assassinate President Ronald Reagan.

On March 30, 1981, John Hinckley Jr. traveled to a hotel in Washington, DC, and made good on his promise. At 1:30 PM, Hinckley stepped forward from a crowd of television reporters and fired six shots from a Rohm R6-14 revolver. The bullets from Hinckley's gun struck Ronald Reagan in the left chest, Press Secretary James Brady in the left temple, Officer Thomas Delahanty in the neck, and Security Agent Timothy J. McCarthy in the stomach.

Hinckley was immediately arrested. His trial began over a year later, on May 4, 1982. On June 21, 1982, after seven weeks of testimony and three days of deliberation by the jury, John Hinckley Jr. was found not guilty by reason of insanity (University of Missouri-Kansas City, n.d.).

Confined to St. Elizabeth's Hospital in Washington, DC, since his trial, Hinckley's obsession with Foster continued. In 1999, however, after significant process in his psychiatric

treatment, Hinckley was allowed to leave the grounds for supervised visits. In April 2000 he won the right to unsupervised furloughs. The following month these rights were revoked when guards found in his room a smuggled book about Jodie Foster—he is banned from having any material about the star. He has always seemed aware of his motivations, even immediately after the shooting. In 1981 he told *Newsweek* "The line dividing life and art can be invisible. After seeing enough hypnotizing movies and reading enough magical books, a fantasy life develops which can either be harmless or quite dangerous" (PBS, n.d.).

My Sister Sam

Paranoid stalkers may believe that a third party is preventing them from consummating their relationship with their fantasy lover. When the object of the stalker's attention says "No," the stalker rationalizes his or her intent away and may then focus on the perceived situation or person the stalker believes is standing in the way of a relationship. "Her husband made her get that restraining order. She really loves me, he is the problem," or "His agent told him it would be bad for his career if we were involved, but he really loves me, that agent better stay out of it." Infamous erotomaniac stalkers include Robert John Bardo, who killed actress Rebecca Schaeffer, and Margaret Ray, who stalked David Letterman and later committed suicide (Kulbarsh, 2007).

For years, Robert John Bardo, an unemployed Tucson, Arizona, fast-food worker, had been stalking Rebecca Schaeffer, the former star of the television series *My Sister Sam*. Bardo hired a private investigator for \$250 to obtain Schaeffer's address through her California motor vehicle record. In July 1989, Bardo showed up at Schaeffer's apartment in the Fairfax District of Los Angeles and fatally shot her as she stood in her doorway.

Bardo's youth was a period of much physical and mental abuse. According to one of his teachers, Bardo was "a time bomb on the verge of exploding" and he wrote his teachers threatening letters. He

was hospitalized two times because of "severe emotional damages" (Wilkins, n.d.). Bardo began to be obsessed with the character Patti, played by Schaeffer. He built a shrine to her in his bedroom.

"She came into my life in the right moment," Bardo stated. "She was brilliant, pretty, outrageous, her innocence impressed me. She turned into a goddess for me, an idol. Since then, I turned an atheist, I only adored her" (Wilkins, n.d.).

On December 20, 1991, Bardo was sentenced to life without parole by Superior Court Judge Dino Fulgoni. Convicted of capital murder, Bardo attempted to explain his actions to Fulgoni: "The idea I killed her for fame is totally ridiculous. I do realize the magnitude of what I've done. I don't think it needs to be compounded by a bunch of lies because she's an actress" (Wilkins, n.d.).

Because of the ease with which Bardo found Schaeffer through her driving records, the incident led to new antistalking laws. The 1994 Driver's Privacy Protection Act (DPPA), which prevents the Department of Motor Vehicles (DMV) from releasing private addresses, was passed in reaction to a series of abuses of drivers' personal information held by government. Other incidents cited by Congress included a ring of Iowa home robbers who targeted victims by writing down the license plates of expensive cars and obtaining home address information from the State's DMV.

Senator Barbara Boxer, who sponsored an earlier version of the DPPA, cited further examples where stalkers were able to find victims by simply visiting a DMV facility. She argued that in "thirty-four states, someone [could] walk into a State Motor Vehicle Department with your license plate number and a few dollars and walk out with your name and home address" (Electronic Privacy Information Center, n.d.).

Boxer further explained:

In Tempe, Arizona, a woman was murdered by a man who had obtained her home address from that State's DMV. And, in California, a

thirty-one-year-old man copied down the license plate numbers of five women in their early twenties, obtained their home address from the DMV and then sent them threatening letters at home (Electronic Privacy Information Center, n.d.).

When the individual was finally apprehended, they found in his possession a book titled *You Can Find Anyone*, which indicated how to do just that using someone's license plate (Electronic Privacy Information Center, n.d.). *How To Find Almost Anyone, Anywhere*, published by Private Investigator Norma Mott Tillman, recommends that the DMV is an excellent place to look for personal information. Tillman says,

Although these records may not be considered public information in every state, most DMVs will release this data if there is "good cause." Most states require as little information as the person's name and date of birth. Databases also allow vehicle license plates and/or vehicle identification numbers to be traced (1995).

Because of its vibrant motion-picture industry, California has a significant population of celebrities, and unfortunately, a grouping of intrusive celebrity stalkers. According to the California legislation, a stalker is defined as "someone who willfully, maliciously, and repeatedly follows or harasses another victim and who makes a credible threat with the intent to place the victim or victim's immediate family in fear of their safety" (National Center for Victims of Crime, 2012). There must be at least two incidents to constitute the crime and show a "continuity of purpose" or credible threat.

Notorious stalkers like Robert John Bardo, Mark David Chapman, Andrew Phillip Cunanan, and John Hinckley Jr., dwelled in a place draped in fear, obsession, and rage. At some point these delusional individuals crossed an invisible line and acted out willful, premeditated rage that has become all too common. By 1993, every state as well as Canada put antistalking laws into effect in an effort to deal with this ongoing, and often deadly, personality

disorder that targets famous celebrities.

C

Maxim W. Furek, MA, CADC, ICADC, is director of Garden Walk Recovery and a researcher of new drug trends. His book, *The Death Proclamation of Generation X: A Self-Fulfilling Prophecy of Goth, Grunge and Heroin, is being used in classrooms at Penn State University and College Misericordia. His rich background includes aspects of psychology, mental health, addictions and music journalism. His forthcoming book, Celebrity Blood Voyeurism, is a work in progress. He can be reached at jungle@epix.net.*



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Older Adults and Casino Gambling: A Case for Social Workers and Counselors

Frances L. Brisbane, PhD



The dramatic growth of the gambling industry, which includes state-run lotteries, casinos, sports wagering, internet gambling, video poker, video keno, and many other forms of betting, has had measurable impact on the older population. For example, it is estimated that 50 percent of Americans over the age of sixty-five gambled in the past year (Desai, Maciejewski, Dausey, Calarone, & Polenza, 2004). While gambling can be an enjoyable activity for many older adults, it is a dangerous addiction for some. With almost one thousand casino venues now operating throughout the United States and more on the way (Barrow & Borges, 2013), it is essential that a comprehensive research study be undertaken to find ways to enhance the positive aspects of recreational gambling and reduce the risks of pathological gambling.

Yes, there can be positive aspects to gambling. According to the Massachusetts Council on Compulsive Gambling, recreational gamblers reported better social support, lower levels of depression, higher self-health, and higher cognitive functioning (Vander Bilt, Dodge, Pandav, Shaffer, & Ganguli, 2004). This finding is consistent with informal research I conducted on numerous bus trips I made from New York to casinos in New Jersey and Connecticut. The bus rides to the casinos were filled with chatter, friendships, and welcoming newcomers, but this was strictly reserved for the bus. Even spouses, relatives, and close friends seldom remained together once they darted out of the bus door to the casino. An overwhelming majority played the slot machines or bingo and their attention was fully devoted to the game they had chosen.

A significant percentage of the casino bus riders I observed appeared to be recreational gamblers who exercised restraint, stayed within their budget, and limited their gaming activities to a few hours. The bus riders spent a majority of their casino experience at the buffet, taking walks inside and outside of the casino, or sitting and waiting for the bus to take them home. Once again my observations were consistent with research that appeared in the *American Journal of Psychiatry* which reported that, "The majority of adults in the United States gamble 'recreationally' at levels not considered problematic or pathological" (Desai et al., 2004).

In view of the fact that many casino customers are retirees who enjoy the social networking to, at, and from the casino, it is not unusual for some seniors to gradually increase their bus trips to the casino to two or three times per week. However, this can easily develop into a risky pattern of recreational gambling that can quickly deplete cash seniors had earmarked for necessities. This risk increases if these seniors live alone in unsafe neighborhoods, live far from children or feel alone, lonely or frightened. I even discovered that some older gamblers who live in dangerous neighborhoods are escorted to the bus stop by their adult children, friends or neighbors who wait until their elder parent or friend is safely on the bus before they leave for work. In the evening when the bus returns from the casino, a relative or friend is waiting at the bus stop to take the elder bus rider home.

Hence, older gamblers can become hooked on *casino* addiction as a prelude to gambling addiction. Sadly, when older adults develop a gambling addiction, they often lose every dollar they budgeted and intended to spend at the

casino, and then dig into their savings at one of the casino's conveniently located ATMs so they can continue to gamble and possibly lose more money. These out-of-control gamblers are at high risk of spiraling into a financial, emotional, and psychological crisis.

Older adults without healthy relationships and social outlets to occupy their time find casinos appealing. Most are not aware that they are among the major supporters of casinos. For this reason, it is vital for state governments to take proactive steps now to prepare for the ongoing casino expansion. Surveys of people who care for and about older adults have found that there is an urgent need for a reliable helpline operated by trained people who can guide callers to helpful services (Wu, 2009). This helpline needs to be operated by social workers who specialize in helping seniors address a wide range of comorbidities including compulsive gambling, loneliness, depression, alcoholism, prescription or illegal drug addiction, neglect, and elder abuse. As reported by the United States Government Accountability Office (GAO), research studies have found that people with gambling disorders often have other behavior problems (2000).

All too often professionals as well as relatives fail to ask older people the type of questions that would reveal the nature of their gambling problems. According to Lia Nower, JD, PhD, an associate professor and director of the Center for Gambling Studies at Rutgers University School of Social Work, "in most social services organizations they screen for alcohol and drugs, but they don't screen for gambling" (Reardon, 2013). Regrettably, signs of depression, loss of social connections, loss of weight, unexplained onset of negative behavior, and other symptoms are attributed as signs of "normal aging conditions." Sadly, not making a therapeutic intervention in a timely manner can contribute to potential suicide, alcoholism, depletion of retirement assets, and unnecessarily living in poverty with physical, mental, and spiritual illnesses.

Older people with substance abuse problems are not likely to seek treatment. They are often too ashamed to admit they have such a problem at their age. They may have the same response of not having a problem with gambling addiction, depression, and incomplete suicides. But when you observe unusual behavior among older people who appear to be neglecting themselves, borrowing money from friends and relatives, using local and state "safety net" institutions and resources when they are receiving Social Security, pension checks, and other types of income, it could be time to make plans for an intervention by a social worker or professional therapist. Then again, when issues such as depression, loneliness, and self-destructive behaviors are treated at an

early stage, the risk of spiraling into full-blown addictions, financial exploitation or elder self-abuse can be drastically reduced.

As it stands now, there are very few reliable resources to help seniors make informed decisions. Websites, texts or phone messages lack the necessary human connection, especially when people have a difficult time expressing a predicament such as compulsive gambling. This is why I strongly recommend that every state that allows casino gambling should include a helpline operated by social workers so that callers will have confidence that help is available from nonjudgmental problem solvers. 

Frances L. Brisbane, PhD, is a professor and dean of the School of Social Welfare at Stony Brook University. Dr. Brisbane has been recognized by the Governor and the New York State Office of Addiction and Substance Abuse Services as one of eight New York State women who made an extraordinary contribution in the 20th Century for student and community education and the prevention of alcoholism and substance abuse.



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Detachment

Rev. Leo Booth



I've just moved into a new house. The house that I left I'd lived in for twenty-five years. It was a great house. I have fond memories of my time living there, but I was ready for a change.

People have asked me, "Was it easy to leave your old house? Don't you miss it?" My answer is "No." Fortunately I'm able to live my life enjoying all my many possessions, but I'm not attached to them; they don't own me. I've developed a spiritual detachment from my material possessions. Indeed, I have a certain detachment from my ideas and opinions.

They don't own me either—I can easily change my mind. If what you are saying makes more sense than what I've been saying for years, then I let it go.

Understanding Detachment

Don't misunderstand me. I'm not saying that I don't have feelings for my old house or my ideas and opinions. Detachment does not mean that I don't care. I care deeply for my life in the old house and I care about my ideas and opinions; it's just that they do not forever define

me. I am more than where I live and what I think.

This is my spiritual understanding of detachment. It allows me to connect with my thinking concerning God's precious gift of freedom. I am free to be involved or I can walk away. In my relationships with other people I've come to understand and appreciate detachment because it emphasizes separation and boundaries. I'm not them and they are not me.

Detachment becomes the healing agent for codependency issues because it acknowledges and

respects a spiritual reality: I cannot change you or make you do something that you don't want to do. Spiritual detachment stops me getting hurt or angry about your behavior which I cannot and will never be able to control. Freedom, in a healthy world, demands an element of detachment, because it highlights the truth that I can only be responsible for my behavior and my actions. You are free to say and do the things that you want to say and do.

The Price of Freedom

I understand that I may not like the things that you are saying or doing, but that is the price of freedom. Spiritual detachment allows me to live with this reality. There is little point in me getting upset about things that I cannot control or determine. Bad things do happen to good people. Good people can occasionally do bad things and bad people can change and do great things. God's gift of freedom allows for the possibility, or better yet probability, of violence, rape, exploitation, and wars. Most of these happenings are not personal. It's not anything we said or did. A spiritual detachment helps us live with the world and people as they are, rather than the fantasy of what we would like them to be.

Just as I'm not willing to have my home or possessions define who I am, neither am I willing to have you, the people I have a relationship with, define who I am. This understanding of detachment has helped me understand God's relationship with the world, and more importantly with me.

God is Detached

While I believe that God truly cares for this world, He has granted to us the gift of freedom. God wants me to be good, but He does not make me good. God wants me to be clean and sober, but He does not make me clean and sober. God wants peace in the world, but He does not stop genocides or holocausts. God is not codependent; He exists in a blessed aura of detachment. This concept has been in my mind for many years and in my book *The Happy Heretic* I write this:

We are beginning to understand that we cannot make somebody happy or healthy; any relationship requires a certain detachment, a respectful space, so that the other person can take

responsibility for their behavior. If we have come to understand this concerning human relationships, then it might also explain our relationships with the Divine. God interacts with creation in a similar manner. God will not fix our health if we continue to overeat or ignore the doctor's advice. If we eat what we like, drink what we want, and do not exercise, then we shouldn't blame God if we have health challenges. We are created to create, and we can also destroy! (p. 111-2).

Greatness

Over the years I've come to understand that this gift of freedom and the possibility of you and I attaining the state of detachment also enables greatness. For example, God does not make the hero, or

the defender of the weak or the spiritual seeker who challenges the religious bigot; that is our job. History is comprised of men and women who, in the face of suffering and persecution, have persevered to do the right thing. Gandhi, Mother Teresa, and Dr. Martin Luther King Jr. are historically recognized, but millions of anonymous people throughout the world have grasped God's gift of freedom and achieved greatness. They have not allowed suffering and bigotry to define them. They have detached themselves from the suffering around them and focused on doing the right thing.

Concerning the focus of *Counselor* magazine, it is important for those of us who work in the field of addiction to attain a state of detachment in our professionalism:

- We care, but we cannot make others get clean and sober.
- We have ideas and opinions, but we are not defined by them.
- We have spiritual insights, but we are forever changing and developing.

And above all this discussion and activity is a God, or a Higher Power, who cares deeply from the pedestal of Divine detachment. 

Leo Booth, a former Episcopal priest, is today a Unity minister. He is also a recovering alcoholic. For more information about Leo Booth and his speaking engagements, visit www.fatherleo.com or e-mail him at fatherleo@fatherleo.com. You can also connect with him on Facebook: Reverend Leo Booth.



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The High Cost of Anger, Part I

John Newport, PhD



Unrestrained anger takes a high toll on our health and well-being.

My experience leads me to believe that alcoholics and addicts are particularly prone to angry outbursts. Caught in the throes of addiction, we often succumb to delusions of grandeur and project an attitude that lets others know “It’s my way or the highway!” Abuse of alcohol and other drugs also makes many people highly irritable. This is due, in part, to serious nutritional imbalances and disruption of sleep accompanying addictive behavior. Substance abuse also impairs our cognitive ability and the desire to keep our anger under control. Unfortunately, many alcoholics and addicts carry their predisposition to unhealthy anger expression over into their recovery.

Appropriate and Inappropriate Expression of Anger

In understanding the negative impact of inappropriate expression of anger we need to distinguish between healthy and unhealthy anger expression. From time to time we all encounter circumstances where it is healthy and even desirable to express our angry feelings. An example

that immediately comes to mind is when someone is verbally abusing us and appears totally oblivious concerning the inappropriateness of their behavior. In the interest of maintaining respect for our legitimate boundaries, in such a situation it is appropriate to tell the offender “You know, what you are saying right now is really upsetting me. Please stop!” This response provides a good example of healthy expression of anger in the form of reporting our feelings, which allows us to communicate our anger in a civilized manner without going overboard.

By contrast, unhealthy anger expression typically “lets it all hang out” and is often delivered with the intent of taking away the recipient’s dignity. Unhealthy anger expression is abusive and is often manifest in the form of extreme verbal, emotional, and/or physical abuse. It often takes the form of “blowing up” with total disregard for the feelings and sensitivities of those around us. More often than not the intensity of the outburst is quite disproportionate to the precipitating incident.

Let us now examine the high costs of uncontrolled anger as it impacts

our health, social relations, sobriety maintenance, and our overall sense of well-being.

Adverse Health Consequences

Growing evidence suggests that unhealthy anger expression increases our susceptibility to a wide variety of illnesses, including heart disease, stroke, hypertension, stomach ulcers, other gastrointestinal disorders, and possibly various forms of cancer (Hafen, 1996).

Research conducted in the 1950s by cardiologists Rosenman and Friedman, which followed over three thousand healthy adult male subjects over an eight-and-a-half-year period, provides a classic illustration of the price of excessive anger in terms of dramatically increased risk of heart disease. At the onset participants were classified into two personality groupings, the overly driven “Type A” personalities and their more relaxed “Type B” counterparts. Friedman suggests that Type A behavior is manifest in three major symptoms: free-floating hostility, chronic impatience, and an exaggerated competitive drive (Friedman & Rosenman, 1959).

Based on data from this long-range study, the authors estimated that Type A behavior doubles the risk of heart disease—the nation’s leading cause of death—in otherwise healthy individuals. More recent research indicates that within the Type A syndrome the behavioral components most associated with increased risk of heart disease include anger, hostility, cynicism, and suspiciousness.

The Rosenman and Friedman study and subsequent research provide sobering data concerning potential consequences of unhealthy expression of anger affecting our health. This is underscored by Meyer Friedman’s estimation that three-fourths of urban men are Type A, and that Type A behavior is becoming increasingly common among women (Friedman, 1996).

Recent literature is replete with references to adverse health repercussions linked to unhealthy

anger expression. Dr. Bradley Bale and his coauthors of *Beat the Heart Attack Gene* offer the following advice: “If you’re prone to high blood pressure, one of the smartest things to do when angry is to check it . . . Individuals who become angry should know how their blood pressure responds. If it’s going up, they need to work diligently to manage their anger with exercise, better sleep, and biofeedback techniques” (2014).

Recently the *Los Angeles Times* reported on an eleven-year study of ten thousand Danish adults aged thirty-six to fifty-two at the study’s onset, designed to test for a possible association between chronic argumentative behavior and premature mortality. Shockingly, findings indicated that middle-aged adults who frequently fought with their spouses were twice as likely to die at a relatively young age compared with people who rarely fought. In aggregate, people who fought frequently with friends were 2.6 times more likely to die prematurely than people who got along with their pals, while subjects reporting frequent fights with neighbors had a three-fold likelihood of dying prematurely (Kaplan, 2014).

While somewhat controversial, a growing body of research has emerged concerning a possible link between chronic suppression of anger and increased likelihood of cancer. Drs. Lawrence LeShan and Bernie Siegel, who have both extensively researched the mind-body connection and cancer, report observations that many people who have cancer have a tendency to refrain from expressing their anger, to suppress their emotions and be overly compliant (Duffy, 2004). Dr. Lydia Temoshok, the director of behavioral medicine at the University of Maryland Medical School, has reviewed numerous studies concerning a possible association between cancer and personality traits, and reports that the most common observations are that cancer appears to be more prevalent among people who may be described as “overly nice” with a marked tendency to suppress their anger (n.d.).

Other Costs of Anger

Unhealthy anger expression obviously takes a heavy toll on the quality of our relationships with spouses and other family members, friends, coworkers, and business associates, not to mention the price we pay in terms of diminished life satisfaction. In addition, it can be a major contributor to job loss and career derailment, as few bosses or associates are willing to indefinitely put up with a chronic “loose cannon.”

I also believe that habitual unhealthy anger expression is a significant contributing factor to relapse to drinking and drug use, as well as failure on the part of many alcoholics and addicts to recognize their problem and seek appropriate treatment. Simply put, chronic rage significantly impairs our ability to take an honest look at ourselves and undertake corrective action.

The next and final installment in this two-part series will present suggestions for minimizing the adverse consequences of unhealthy means of expressing our anger as they affect our health, sobriety maintenance, and overall well-being. In the meantime, I encourage you to reflect on your own patterns of dealing with anger, together with possible steps you may want to take toward modifying this

behavior. Until next time—to your health! 

John Newport, PhD, is an addiction specialist, writer, and speaker living in Tucson, Arizona. He is the author of *The Wellness-Recovery Connection: Charting Your Pathway to Optimal Health While Recovering from Alcoholism and Drug Addiction*. His website, www.wellnessandrecovery.com, provides information on wellness and recovery training, personalized wellness counseling by telephone, and program consultation services.



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Accessing Inner Power with Breath

Sheri Laine, LAc, Dipl. Ac



What does it mean to be grounded and centered in our body? In the study of Oriental Medicine, we focus on one's breath; the feeling of circulating our Qi (life force) and the connection to our inhalations and exhalations.

If you practice Qigong or tai chi, part of the exercise—along with the movements—is the use of your abdominal breath as a powerful source of Qi revitalization and movement. Using your breath is another excellent way to calm your mind and reach down into the reservoir of inner strength that you always have available within your own body.

Acupuncture is another way to access this state of equilibrium. The circulation of blood, oxygen, and Qi throughout the body and mind during a treatment is often described as “deeply relaxing” and “transcendent.”

In Oriental Medicine, our center (also known as the “Dan Tian”) is located approximately two finger breaths below the navel and above the pubic bone. We think of the Dan Tian as a holder for our body's powerful Qi.

If your Dan Tian power is strong and vital, chances are the functions of digestion, elimination, and fertility will

be as well. You feel calm and balanced throughout the day. It becomes easier to make positive empowering choices when the Qi is flowing smoothly. With this sense of balance comes the feeling of emotional stability and connection to our healthiest self.

On the flip side, if stress, addictions, fear, anxiety, lack of sleep and regular exercise, along with unhealthy eating, has become a bigger part of your everyday lifestyle, you may feel as if your nervous system is ready for a reboot.

Your mind can take you anywhere you let it, as can your nervous system. When we quiet the mind with meditative breath, a deep relaxation and reprogramming process occurs throughout our entire body. As controlled breath deepens, the power of the Dan Tian can begin its revitalization and circulation process.

Try this simple breathing exercise:

1. Get comfortable, sitting or lying on your back with your neck supported. Soft relaxing music is lovely, but not necessary.
2. Gently close your eyes. Relax the muscles around your eyes, in your face, in your jaw, and in your neck. Relax your stomach, arms, hands, fingers, legs, feet, and toes. This feeling is akin to floating on a raft in the water.
3. Slightly open your jaw and relax your lips as you begin to slowly breathe through your nose.
4. Feel your breath rise and fall through your body. Imagine that you are filling up a warm golden orb of light in your lower belly. As your lungs empty, try pushing out a bit more breath. As your lungs fill again, try to take in a bit more breath.

5. Every inhalation is calmness and vitality filling you up from your head to your toes, while every exhalation is tension leaving you from your head to your toes.

If you find your body drifting off, don't fight it. Allow yourself to relax into where the moment takes you. If your mind starts to wander into everyday thoughts, bring your thoughts back to the vision of light in your lower abdomen, filling you with every exhalation and inhalation.

Practice every day, starting with five-minute breathing sessions, working your way up to ten to twenty-five minutes each time.

As you become more and more comfortable with using revitalizing breath in your everyday life, you will notice that your ability to relax and use your breath in stressful situations becomes easier. Most of us breathe with shallow, short breaths into our chest rather than reaching down with long, languid breaths into the Dan Tian.

Using your breath is an uncanny, yet powerful way to take a private moment, calm your emotions, and collect your thoughts. This technique can become another important tool which you can easily access at any time to stay in touch with your inner wisdom, calmness, and empowered vitality. 

Sheri Laine, LAc, Dipl.

Ac., author of *The EnerQi Connection*, is a California-state and national certified acupuncturist/herbologist licensed in Oriental Medicine. She has been in private clinical practice in Southern California for twenty-five years.

In addition to teaching, Sheri speaks throughout the country about the benefits of integrative living and how to achieve a balanced lifestyle. Please visit her at www.BalancedEnerQi.com.



Interventions to Enhance Motivation: The Client's Perspective, Part III

Dennis C. Daley, PhD

This is the final column on motivation. The first two addressed levels of client motivation to change, factors impacting on motivation, and strategies for clients to address motivation issues. This column discusses evidenced-based motivational approaches and clinical strategies to address motivation issues with clients.

Motivational Interventions

There are two motivational interventions that have significant research support and can be integrated into clinical practice and treatment programs: motivational interviewing (MI) and motivational incentives (MotInc), also called "contingency management" (Miller & Rollnick, 2012; NIDA, 2012; Stitzer, Petry, & Peirce, 2010; Wells, Saxon, Calsyn, Jackson, & Donovan, 2010). MI helps clients develop internal motivation to change as well as deal with ambivalence to change or factors that interfere with the change process. MI is effective with substance use, psychiatric, and medical disorders. MotInc is more of an external motivator that leads

to improved substance use or mental health outcomes and session attendance. The reinforcement provided by external incentives helps the client make positive changes that can be sustained over time with other types of interventions that impact on internal motivators. In one of our quality improvement initiatives in a co-occurring disorders partial hospital treatment program, MotInc has a significant impact on increasing program attendance. External motivators can provide time for clients to internalize motivation to recover.

Helping Clients Increase Motivation

Clients are often bombarded with internal cues (memories, thoughts, feelings, desires) as well as external cues (signs, smells, reminders, people, places, things, events) to use substances, which impact their motivation to continue recovery disciplines. I asked clients in several treatment groups to identify coping strategies that help them through periods of low motivation or increase their motivation to recover. I also asked several clinicians for their ideas on ways





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to help clients deal with motivational issues. All agree that education and awareness of motivational issues can have a positive impact on recovery. The following are some specific strategies to enhance motivation.

Assess the Stage of Change and Current Level of Motivation

While helping clients deal with low motivation or increasing motivation to change can occur in any stage of the change process, clients in the precontemplation or contemplation stages often require the most effort related to their motivation to change. It makes little sense to focus on relapse issues with clients who are not sure if they even want to stop using alcohol or other drugs. Since level of motivation can change frequently in the early phases of treatment and recovery, regular assessment of the client's current motivation enables the clinician to determine intervention strategies.

Setting Goals for Recovery

Clients benefit from having a direction to follow in managing their disorders. This may require them to listen to, and to let others influence, their behaviors regardless of their level of motivation to change. Or, as one clinician with decades of personal recovery stated, "In early recovery, you should be like a horse with blinders and let others guide you towards reaching the goal of sobriety." This is a good example of the need to "surrender" and let others support and facilitate recovery.

Thinking Differently

Attending treatment sessions and mutual support meetings, even when the client does not feel like it, often has a positive outcome. Or, as many people in recovery have stated about

attending sessions or meetings when they did not feel like it, "drag your body and your mind will follow." Sometimes clients have to take action even when they do not feel like it.

When a client moves from thinking, "I cannot drink or use drugs because of the negative consequences" to "I can not drink or use drugs because I do not want to," this indicates that motivation has moved from external to internal. The client is now showing recovery thinking.

Keeping a Daily Log of Motivation

This is similar to keeping a "mood thermometer" or "daily craving log" to monitor specific psychiatric symptoms or issues such as obsessions or cravings for alcohol or drugs. Clients attending structured programs can report their levels of motivation during check-in periods. This enables clinical staff and their peers to be aware of any significant changes in motivation. This also provides a context in which a client can get help and support with any current motivational issue. When I ask groups of clients if they thought about not coming to the program the day I meet with them, the majority acknowledge this thought crossed their mind. More importantly, they were able to share self-talk strategies they used to convince themselves to attend the program, regardless of how low their motivation was at that time.

Using a Decision Matrix

This was developed by Dr. G. Alan Marlatt as an exercise aimed to help the client see both types of decisions related to using or not using a substance or engaging in an addictive behavior such as compulsive gambling or overeating. This can be adapted to behaviors such as taking or not taking medications for a psychiatric illness or substance addiction, attending treatment or mutual support programs or engaging in any specific behavior (e.g., quitting a job or sticking with it; trying a new leisure activity; paying bills or going on a shopping spree; controlling anger or expressing it in inappropriate ways; asking a confidante for help or support or keeping personal struggles to oneself). A client can review the results of any decision matrix in a group session with peers, or an individual counseling session. Seeing both short- and long-term positive and negative aspects of any decision enables the client to think about options to change, potential barriers, and potential benefits.

Accepting Small Steps to Success

A client with a chronic or persistent psychiatric disorder has to accept that not all symptoms may totally disappear, and that some symptoms have to be endured; these are referred to "persistent symptoms." Or, a client with a history of multiple relapses to addiction may have to fight through strong drug cravings or periods of low motivation. Even a modest decrease in psychotic, mood or addiction-related symptoms, or a modest increase in motivation to recovery, is a step in the right direction and evidence of improvement.

Maintaining Daily Recovery Disciplines

Incorporating recovery into daily life can involve meeting or talking with a sponsor, a peer in recovery or other support

person; attending mutual support meetings; reading recovery literature or listening to recovery stories on audiotapes or DVDs; or being of service to others (e.g., helping to set up or clean up after meetings or giving a peer a ride to a meeting). These are reminders of where one has been, that negative emotions or moods can be managed, and that recovery can continue regardless of what a client faces in daily life.

Reaching Out

It helps if a client has a list of at least five people to rely on that can be contacted during periods of need as well as during periods when things go well. A regular connection with a recovery support system promotes accountability with others who know the client and his or her recovery plan. As one woman stated, “When I tell my husband I feel headed towards depression, he helps me get through it. If I don’t tell him, my depression is more likely to pull me down.”

Engaging in Pleasant and Healthy Activities

These support the client’s recovery and promote well-being, which can enhance motivation to change. These can include regular physical workouts, praying, attending religious or spiritual activities, meditating, practicing mindfulness or participating in any organized group or activity that brings the client meaning or enjoyment. The “fly by the seat of my pants” and “engage in healthy activities only when I feel like it” approaches usually do not work in the long run. Keeping reminders of progress, such as calendars, journals, logs or coins given at Twelve Step meetings for specific periods of sobriety, and sharing events with peers (e.g., first thirty days sober with a stable mood or without any self-harm activities) can reinforce positive decisions.



Observations

- While MI has been adapted by many clinicians across behavioral health care systems, MotInc is used less frequently. There is still some resistance to the idea of “rewarding” clients for not using substances or attending sessions.
- Ambulatory treatment programs who use MotInc to increase attendance will find a significant return on their financial investment. For example, increasing daily attendance in a four- to six-week partial hospital program by five days per patient over the course of treatment can generate \$500 for programs that receive \$100 for a treatment day or \$1250 for programs that receive \$250 for a treatment day (less cost of incentives).

Questions to Consider

- What have you found helpful in working with clients to address motivational struggles related to their disorders or any lifestyle issue?
- Rather than give up on a client who has had multiple relapses and chronic struggles with motivation, do you think of other ways you may reach this person and affect recovery?
- If your program has a problem with poor adherence to treatment by clients, have you considered implementing a motivational incentives program to improve adherence?

Evidenced-based motivational approaches (MI and MotInc) can easily be incorporated into clinical services and have a positive impact on outcomes for clients. It is important, however, to insure clinicians have access to ongoing training, supervision, and/or consultation as a mechanism to sustain the use of these approaches. There are many clinical strategies that can be used in individual or group sessions to educate clients and help them learn ways to deal with motivational struggles as these are so common in recovery, regardless of one’s disorders. Catching and addressing motivational struggles early can enhance a client’s recovery. 

Dennis C. Daley, PhD, served for fourteen years as the chief of Addiction Medicine Services (AMS) at Western Psychiatric Institute and Clinic (WPIC) of the University of Pittsburgh School of Medicine. Dr. Daley has been with WPIC since 1986 and previously served as director of Family Studies and Social Work. He is currently involved in clinical care, teaching, and research.



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You Need Critical Thinking, Part I

Michael J. Taleff, PhD, CSAC, MAC

You might be asking yourself what in the world critical thinking has to do with a research to practice column. The answer is this: everything. The point of all these columns has been to present better treatment options for your clients. A big piece of determining what “better” means is utilizing a process called critical thinking, which helps separate the crappy stuff from the good stuff. You, the practitioner, should be able to know the difference, and critical thinking will help with that. But, it also means honing your clinical skills and clinical thought so with each passing year you become better at your job.

For example, if you’ve been in this field for any length of time, you’ve probably sat through your fair share of staff meetings. During those meetings, you doubtless heard some pretty far-fetched ideas expressed to explain client behavior. Listening, you may found yourself wondering, “How in the world did that person come up with that #*%@% idea?” Perhaps someone even wondered the same thing about you.

Now, fanciful client descriptions don’t only appear in staff meetings—they pop up in addiction workshops and literature as well. They all bear certain

distinguishing marks like an overreliance on authority, a preference for stories over statistics, and oversimplifying complex problems (Shermer, 1997; Kida, 2006; Taleff, 2006). These biases fog clinical thought and sow the seeds of dubious addiction beliefs. They lay at the polar opposite of quality clinical thinking. If allowed to persist, these biases can be detrimental to how we assess our clients, and the way we select treatment for our clients. How can poor thinking do all that? It’s because the key clinical skills so essential in our field fall prey to the distortion and spin caused of these biases and a host of other fallacies. Simply, bias and fallacy type thinking in addiction treatment is not good.

Keeping your mind crisp for the important work we do requires a few critical thinking tips. That’s the general goal for Parts I and II of this column. In Part I, you just met a short overview of biases that jeopardize solid thought. We next address three significant biases that can be particularly troublesome for our field.

Confirmation Bias

Sometimes referred to as the granddaddy of all biases is the one called “confirmation bias.” It’s a selective thinking process where individuals tend to confirm their own beliefs, while avoiding, undervaluing or discarding information that contradicts those beliefs. Here one sees reality as they wish to see it. People caught in this bias push away threatening information and pull friendly, confirming information close. For example, say you’re absolutely convinced a client is in denial. Confirmation bias will sway you to seek only those client behaviors that confirm your denial belief. So, if “the client is in denial” is the belief, you will begin to see and observe nothing else. Even when clients do begin to come to terms with their addiction, you will still be swayed by confirmation bias, will sweep this behavior aside, and will look instead for any ongoing or telltale signs of denial or contrived notions to confirm your belief. For example, “You’re not being honest. You’re still in denial.” Influenced by the confirmation bias is a jaundiced clinical judgment.

Alas, confirmation bias doesn't end with clinicians; it is also found with researchers. In this case, some researchers are guilty of setting up experiments or framing their data to confirm the hypothesis they're testing. Some will compound their problem by simply avoiding the data that contradicts their own findings. By the way, this is not to be taken as a slight on science and research. Sooner or later such faulty findings will be exposed through additional research. That's the big strength of research and critical thinking. Faults, biases, and fallacies are all exposed sooner or later, and the good research data is revealed.

Why would people sweep away disconfirming information? A big reason seems to be due to a concept called "cognitive dissonance" or excessive mental discomfort or stress. It is experienced by someone who holds two or more opposing beliefs, ideas or values in their head at the same time. In some cases this is quite uncomfortable, and who wants to feel uncomfortable? So, the one with the dissonance feels the need to reduce the discomfort and avoid information that leads to the dissonance in the first place. Basically, the individual wants their feeling of consistency back by reducing the dissonance. That means sweeping away information that does not jive with a core belief. Keep the contradictory information at bay and the dissonance goes away, but at an enormous price.

Anchoring Bias

"Anchoring" is the tendency of humans—and addiction practitioners—to rely too strongly on one piece of information, one characteristic or concept. Individuals who do this are said to anchor or attach themselves excessively to certain information, characteristics or ideas. Anchoring affects clinical decisions by smothering out other kinds of clinical information that might prove beneficial to the addiction professional. Examples include attending a workshop or reading an article and there after seeing all your clients as the workshop or article describes. While such information may apply to *some* of your clients, no workshop, article or book information

applies to all your clients. One example is of those who rely too heavily on the concepts of the learning theory or the disease model, or any such addiction theory for that matter. Pretty much any client behavior that comes into one's care will be framed in terms of the anchored learning or disease model. Not much else is utilized to explain client behavior save what the counselor has anchored to. So, those who anchor to the learning theory, or disease model or whatever, have a difficult time seeing other assessment or treatment possibilities that might better suit a client. Anchoring is a bias that limits clinical possibilities. Addiction professionals need more clinical options, not less of them.

Availability Bias

Availability bias is a common mistake when it comes to appraising wide-ranging evidence and/or clinical data. We commit this error when we rely on evidence or clinical facts not because the facts are trustworthy, but because the facts are striking or memorable (Taleff, 2006; Vaughn, 2008). This striking effect is different from the anchoring bias that banks on one piece of information. In terms of availability, if a vivid clinical example is available in our head we tend to see other clients in the same vivid framework (Grambrill, 2006). Vivid clinical examples are easily retrieved from our memory, hence the reason we tend to perceive them first and then rely on them while ignoring conflicting evidence (Kahneman, 2011). For example, say you found that a number of your clients relapsed shortly after discharge from your program. Relapse is often a striking memorable event. It stands out in an addiction professional's mind. In this example, your vivid relapse memory has you begin to believe that your present clients will also relapse, thus causing you to spend more time on relapse prevention. While this seems like a prudent clinical decision, the problem is that you take time and effort from other clinical issues that may be more relevant to present client needs, as in the need for couples therapy, PTSD work or some other such necessity. The availability bias will skew your clinical judgment. That's its power.

Conclusion

Hopefully by now some of you are saying to yourself, "How do I protect myself from these biases?" That is a very good question that has no simple answer. While we will address this question in more depth in Part II, for the time being consider that you need to think about your thinking. Start by noticing if you fall for the biases listed above in the first place, which will require some effort on your part. If you notice a propensity to fall for the confirmation bias, next comes the courage to bring yourself to seriously read and examine the data, research or ideas opposed to your bias. Following that process, you can make better assessments and treatment selections. The same process of first noticing, then finding the courage to examine other views applies to the availability and anchoring biases.

In Part II of this two-part series, we will visit a few more bothersome fallacies found in our field and address what you can do to avoid them. **C**

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The Use and Misuse of Language by Addiction Counselors, Part II

Gerald D. Shulman, MA, MAC, FACATA



This is the second part of a three-part series focusing on terms related to addiction and their correct and incorrect uses.

“Binge Drinking”

According to the National Institute on Alcohol Abuse and Alcoholism, binge drinking is defined as a pattern of alcohol consumption that brings the blood alcohol concentration (BAC) level to 0.08 percent or more (n.d.). This pattern of drinking usually corresponds to five or more drinks on a single occasion for

men or four or more drinks on a single occasion for women, generally within about two hours. It is also sometimes used to describe an extended period of heavy drinking by someone who has a severe alcohol use disorder.

“Client” vs. “Patient”

The term “client” is often used to describe the individual being assessed and/or treated by nonmedical clinicians, usually other than psychologists. The term is universally used in state alcohol and drug standards and in publicly

funded treatment programs. However, consider that if the people we treat are “sick” or suffer from a disease, it is more appropriate to characterize them as “patients” regardless of who provides the treatment or funding or reimbursement for treatment. Attorneys have clients. We have patients. Additionally, during utilization review with payers, the use of the term “patients” rather than “clients” is likely to resonate with the reviewer and fit with the type of people who have conditions for which insurance pays.

“Codependence”

This term can be problematic. It was originally coined by the National Association of Children of Alcoholics (NACoA) and it identified an important syndrome often found in adult children of alcoholics, characterized by dependence on the needs of, or control of, another. It also often involves placing a lower priority on one's own needs, while being excessively preoccupied with the needs of others. However, in common usage it was applied so broadly as to lose any specificity (“95 percent of the world is codependent and the other 5 percent is in denial!”). It is sometimes applied to people who actually meet criteria for a personality disorder. Most importantly, it does not exist in any generally accepted diagnostic classification, such as the DSM-IV, DSM-5, ICD-9-CM or ICD-10-CM. Caution should be exercised in using the term “codependence” to justify admission or continued treatment when doing a utilization review with a managed care reviewer, so as not to create a credibility problem.

“Compliance” vs. “Adherence”

“Compliance” implies going along, acquiescing or submitting because of external pressure in contrast to “adherence” which implies more internal motivation. Patients in treatment comply with treatment and may sound like they are making progress while they are really “doing time,” not “doing treatment.” Furthermore, “adherence” is strength-based and patient-centered.

“Comorbidity”

“Comorbidity” is a medical term for illnesses that coexist, regardless of primacy or causal connections. In behavioral health, it was previously referred to as “dual-diagnosis,” but is now referred to as “co-occurring.”

“Continuing Care”

More commonly called “aftercare,” this term usually refers to the professionally or peer-directed treatment (usually group) that occurs after the completion of primary treatment and is designed

to solidify the gains made in treatment, facilitate the process of coping with the stresses of early recovery, and reduce the potential for relapse.

“Controlled Drinking”

While this term may be used to describe nonproblem drinking, it is more frequently used in the context of an individual who has an alcohol use disorder and appears able to return to nonproblem or social drinking. While this may be possible for individuals with a mild severity alcohol use disorder, it appears not possible for someone who has a severe alcohol use disorder (e.g., alcohol dependence in the DSM-IV).

“Co-Occurring Disorders”

The current term replaces “dual-diagnosis,” and describes the concurrent existence of two or more types of disorders. While commonly used to describe the coexistence of a substance use and mental health disorder, it is not limited to that. For example, a patient may have an opioid dependence, a chronic pain disorder, hepatitis C, and a major depressive disorder. The term does not speak to causal relationships between the disorders or which is primary and which secondary. The advantage of this term over “dual-diagnosis” is that it does not limit co-occurring disorders to only two disorders and avoids the mistake of interpreting the term as being limited in application to only having both an alcohol or drug use disorder and a mental health disorder.

“Dependence”

This term is used in a number of different ways. In general usage, it is described as the state of relying on or needing someone or something for aid, support or the like. In the section on substance use disorders of the DSM-IV, it was a diagnosis of a more severe level of disorder made by meeting three or more of the seven dependence criteria. However, it is no longer a diagnosis in the DSM-5. It is also used to reference physiological reliance on a substance and used as a synonym for addiction as in “drug dependence.”

“Detoxification”

This is the metabolic process by which toxins are changed (broken down) into less toxic or more readily excretable substances by the body. The period of time over which this takes place is dependent on a number of factors including the half-life of the drug, the age and physical condition of the patient, and different substances used concurrently. The term is very commonly misused to describe treatment provided to alleviate adverse physical or psychological reactions to the withdrawal process. The new *ASAM Criteria* has replaced the term “detoxification” when used to describe a level of care, the setting or the medical management processes with “withdrawal management.”

“Discharge” vs. “Transfer”

“Discharge” denotes the termination of an episode of treatment while “transfer” implies movement from one type of treatment or level of care to another. The terms are sometimes used interchangeably because of insurance benefit language.

“Disease Concept”

This term may have made its first appearance in the book *The Disease Concept of Alcoholism*, written by E. M. Jellinek in the 1950s. The results of the brain research during the last decade have conclusively proven that addiction is a chronic, relapsing brain disease. If that is now a recognized fact, why do we still refer to it as a “concept?” When speaking about the disease, it is more appropriate to refer to it as the “disease model.”

“Dual-Diagnosis”

A term used to describe the concurrent existence of two types of disorders, usually a substance use and mental health disorder. The concept of “dual” inaccurately limits the number of concurrent disorders to two (see “Co-Occurring Disorders”).

“Early-Onset Alcoholics”

This term is often used to denote the age of onset of a substance use disorder in older adults. Although there is not total

agreement in the literature as to what constitutes that age, the dividing line between early- and late-onset is often identified as forty-five years of age, regardless of the age of the individual at the time of the assessment. Because of their long histories of use by the time a treatment intervention occurs, early-onset alcoholics are more likely to have more serious medical and possibly psychiatric problems, multiple treatment experiences, family estrangement, and fewer social supports. The likelihood of successful recovery appears poorer than for late-onset alcoholics, who often develop the disorder as a result of the stresses of aging (retirement, widowhood, loneliness, isolation, etc.). Late-onset alcoholics have a history of accomplishment prior to the onset of the alcoholism including education, job skills, employment history, and family connections and are generally assumed to have better coping skills than early-onset alcoholics.

“Gambling Disorder”

“Gambling disorder” is now part of the Substance-Related and Addictive Disorders section in the DSM-5. The term “gambling disorder” replaces “pathological gambling,” listed as an impulse control disorder in the DSM-IV and commonly referred to as “compulsive gambling.” It frequently co-occurs with substance use disorders and its diagnostic criteria are very similar to those for substance use disorders.

“Gateway Drug”

This is the belief that the use of certain drugs predisposes use to another, usually more serious drug use. Cannabis is often referred to as a gateway drug and the research is mixed. The belief probably comes from awareness that people, particularly adolescents, who use marijuana are also likely to use other, more “serious” drugs. What is missing is the documentation of a causal relationship between marijuana and the other drug use. People who use substances are likely to use a variety of psychoactive substances. However, if we examine the belief of a causal connection between use of a specific drug and later use of other drugs, we find that the drug

most frequently used by heroin addicts before their heroin use is alcohol, yet people are unlikely to postulate a causal relationship between drinking and later heroin use. If there is a gateway drug, it might be tobacco and although there is no evidence of a causal relationship between smoking and other drug use, smoking is commonly found associated with other drug use and preceding or co-occurring with the other substance use disorders (think smoking among alcoholics). It is apparent that to find adolescents who are using alcohol and/or other drugs in school, one needs only to find adolescents who smoke.

“Graduation” (From Treatment)

This is a term often used in place of “discharge.” One graduates when one completes an educational or academic experience. Since addictive disorders are illnesses requiring treatment, and education alone does not change behavior—if it did no one would still be smoking—“graduation” is an inappropriate term to apply to discharge from treatment. If an individual is hospitalized for the treatment of asthma, they do not “graduate” from the hospital. The use of the term might stem from the still common use of fixed length treatment—the twenty-eight-day, inpatient treatment program.

“Habilitation” vs. “Rehabilitation”

Rehabilitation implies a return to an earlier level of successful functioning. There are patients, who because of the age at which they began using substances or other reasons, have no history of successful functioning prior to their use of substances. For them, the more accurate term is “habilitation,” developing that level of successful functioning for the first



time. Habilitation is differentiated from rehabilitation by the necessity for more skill-building activities.

“Habit”

This term is incorrectly used to describe addiction. A habit implies certain behaviors which become routine, repetitive, and which can be positive (good habits like exercising regularly) or negative (bad habits like biting one’s nails). Addiction is a disease and to refer to it as a habit minimizes its seriousness.

“Heavy Drinker”

Another undefined term which could mean anyone who drinks and weighs over 250 pounds.

The next and final installment of “Counselor Concerns” will pick up where we left off and discuss terms such as “motivation,” “recovery,” and “tolerance.” 

Gerald Shulman is a clinical psychologist, master addiction counselor, and fellow of the American College of Addiction Treatment Administrators. He has been providing treatment or clinically or administratively supervising the delivery of care to alcoholics and drug addicts since 1962.



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Adolescent Gambling as a High-Risk Behavior

Fred J. Dyer, MA, CADC



Growing up in Michigan City, Indiana—yes, I’m a Hoosier—I hung around boys who played marbles. As I entered junior high, we pitched pennies, dimes, and quarters. Then in high school, behind one of the doors where no one entered or exited, we shot dice. Interestingly, those who shot dice were a diverse group; at any given time you would have seen African American, Caucasian, Latino, and Hispanic boys, and possibly even an adolescent girl in the mix. While the aforementioned activities may appear innocuous, they are sometimes precursors to high-risk behaviors that can lead to problem gambling among youth, which is now

a growing public health concern.

While gambling is predominantly viewed as a harmless adult pastime, more underage youth exposed to the widespread availability of regulated and unregulated forms are succumbing to the temptations and pressures to participate in these activities (Jacobs, 2000; National Research Council, 1999). Similar to adults, research reveals that problem gambling during adolescence can lead to adverse outcomes such as strained relationships, delinquency, criminal behavior, depression, and even suicide (Derevensky, Gupta, Messerlian, & Gillespie, 2004). Such

negative outcomes have short- and long-term implications for individuals, significant others, and society at large (Derevensky, Gupta, Hardoon, Dickson, & Dequire, 2003). Yet, despite these negative consequences, problem gambling in youth has only recently emerged as a significant public health concern (Korn & Shaffer, 1999).

In analyzing the cost and consequences of youth gambling as a public health problem, research has demonstrated that problem gambling among adolescents has been associated with a number of other mental health outcomes, including higher rates of depression symptomatology, increased risk of alcohol and substance use disorders (Hardoon, Derevensky, & Gupta, 2002), increased risk of suicidal ideation and attempts, prior anxiety (Gupta & Derevensky, 1998), and poor general health (Potenza, Fiellin, Heninger, Rounsaville, & Mazure, 2002). Further, these adolescents, relative to their peers, are at increased risk of delinquency and crime, disrupted familial and/or peer relationships, and poor academic performance (Wynne, Smith, & Jacobs, 1996). The consequences borne by youth experiencing gambling-related problems are serious, and the damage can be devastating to the

adolescent and his or her peers and family.

In any discussion of adolescent behavior, it is always necessary to understand adolescent developmental issues and that the nature of adolescence is a stage of risk-taking experimentation for acceptance by peers and group conformity. Equally, adolescence is a period of profound brain maturation. It is commonly believed that brain development is completed during childhood, but in fact the maturation process of brain development is actually not complete until about age twenty-four or twenty-five.

There is considerable empirical support suggesting that gambling involves a complex and dynamic interaction among ecological, psychophysiological, developmental, cognitive, and behavioral components and that problem gamblers are not a homogenous group. Given these assumptions, Gupta and Derevensky (2000, 2004) contend that in the absence of empirically validated treatment programs, a dynamic approach needs to take into account the multiplicity of interacting factors in a treatment paradigm for youth experiencing significant gambling problems. It is necessary in constructing treatment and prevention policies and programs for youth and to develop a profile of the adolescent problem gambler. The International Centre for Youth Gambling Problems and High Risk Behaviors in Quebec, Canada, provides the following profile of such a gambler (2013):

- Predominantly male
- Significant anxiety
- Familial problems and poor peer relationships
- Preoccupation with gambling and reported inability to stop despite repeated efforts
- Serious financial difficulties
- Failure in school and/or at work
- Lying to family and friends
- Friends usually have similar gambling problems
- Stealing from family, friends, and stores; bank fraud
- Depression or feeling dead inside
- Gambling to escape and feel better
- General lack of effective coping abilities and problem-solving skills
- Confused and conflicted about whether they really need to stop gambling
- Need for arousal or strong sensations

Gambling studies contend that treating gambling problems in isolation from other pressing social, physiological, developmental, cognitive, and emotional difficulties may lead to short-term success but will ultimately lead to relapse. In addressing prevention initiatives, limited progress has been made in understanding the treatment of problem adolescent gambling and the characteristics of those seeking help—empirical knowledge concerning the prevention of gambling problems and its translation

into science-based prevention initiatives is similarly scarce (Derevensky, Gupta, Dickson, & Deguire, 2001). Nevertheless, Gupta and Derevensky (2000) provide a comprehensive review and list of current programs on the increasing widespread use of harm reduction in the field of alcohol and substance abuse, which may be a useful strategy in preventing gambling problems (Dickson, Derevensky, & Gupta, 2004).

As an overarching framework, harm reduction is drawn from the alcohol literature and includes strategies, policies, and programs designed to promote reduction and responsible gambling without requiring abstinence (Riley et al., 1999). While controversial to some—recovering pathological gamblers often prefer that abstinence be emphasized—this framework includes secondary prevention strategies predicated upon the belief that it is not only feasible but highly unlikely that one can prevent individuals from participating in particular risky behaviors (Baer, MacLean, & Marlatt, 1998). It is important to note that a responsible approach to preventing adolescent gambling problems, such as incorporating a harm minimization approach, does not preclude abstinence, especially for young children. Acceptance of harm reduction as a health strategy and as an interim step toward an abstinence model supports an initiative designed to reduce and minimize the harmful negative consequences incurred through involvement in

risky behaviors (Dickson et al., 2004).

Youth gambling is a hidden addiction and is similar to other addictions. It comes with a host of negative consequences and problems. Those of us who work with and care about adolescents should assist them in generating opportunities for prosocial activities, such as Boy Scouts, Girl Scouts, Boys and Girls Clubs, sports, and other activities that do not require engaging in risky behaviors, because adolescence, as a developmental phase and without supervision and guidance, can be a risky period of life. **C**

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Ask the LifeQuake Doctor

Dr. Toni Galardi



Dear Dr. Toni:

I read your column at the home of a friend who works in the addiction field. I have never written to an advice columnist before. I graduated from an Ivy League college a month ago. I am twenty-two years old and I have never had a serious relationship. They all start out great, but I get attached very quickly, the guy distances himself, and it pretty much ends.

I find myself questioning if I should continue dating guys. I fail miserably at understanding men. I get along much more easily with women and some of my girlfriends have chosen to give up men and are in happy relationships with women. Do you think I should give it a try? I come from a wealthy family and my parents would be mortified if I came out as a lesbian. They are still supporting me as I try and break into acting in New York. What should I do?

—Confused in the Big Apple

Dear Reader:

Before you give up on men, perhaps you might examine why you get attached so quickly. Do you have sex with them early on in the dating courtship? I use the word “courtship” because, although it is an old-fashioned word for young people, if what you want is a committed relationship then you need to separate inspiring a guy to court you from sleeping with him. Having sex is best left to a time when you both decide you are ready to make your relationship monogamous. That is the second phase of a relationship. The bonding hormone (oxytocin) gets especially stimulated in women when we have sex, so we don’t necessarily make the best decisions as to whether the guy is relationship material when we’re drunk on sex hormones.

*Another way to not get attached too quickly is to date more than one person at a time. Read the book *The Four Man Plan*. You are young, and you probably have the energy to juggle more than one guy. It will also make you more desirable in their eyes; men like a little competition.*

Now, to address your inquiry about women; you don't mention if you have ever been attracted to a woman or experimented with being sexually intimate with women. If you have and you enjoyed it, then perhaps there is another issue here. Maybe the heavy attachment to men right away is a compensation for trying to avoid facing any upheaval that would come from dating women. I posit both sides to this so you can do some soul-searching. Notice how you feel when you are around your women friends. Is there any sexual arousal or do you merely feel more comfortable than with men on dates?

If you merely feel safer around women, make a choice for going slow with guys. Insist on taking the time to develop a friendship first. Experiment with giving yourself a ten-date rule with a minimum of one month before any sexual intimacy.



Dear Dr. Toni:

I have been in ACoA recovery for about twenty years. I am fifty years old, have two children, and have a thriving yoga business. My mother, however, is still a raging alcoholic and is now showing signs of dementia. She and my stepfather live in a nursing home; I have taken care of her estate. Mostly this consists of hiring people for upkeep of her home, which I do from long distance but occasionally have to fly across country to attend to her affairs. Recently, I asked my stepfather for reimbursement for some of my traveling expenses and the costs of some home repairs that I paid for.

He and my mother became enraged that I would ask for reimbursement. This has triggered so many old memories of me taking care of her when I was a child and feeling like she was a bottomless pit of need with no gratitude. I am not her guardian, but I don't think she is capable of handling her estate on her own and I would like to have some kind of nest egg for my children.

Should I just drop the expectations of reimbursement and just be in service?

—Frustrated Yogi

Dear Reader:

You say you have been in recovery for twenty years. First of all, I would urge you to go to a meeting and get a sponsor if you don't already have one.



Unless you are prepared to step into moving for guardianship, you have two choices: walk away and let go of any expectations of an inheritance or engage the yogic practice of seva (selfless service). In order to truly practice seva, you must know that you can truly let go of any expectation of any reward from your efforts. If you cannot do this, from a recovery point of view it is unhealthy to continue to feel like a doormat to your mother's narcissism. If you are a yoga teacher, I imagine you meditate. I would encourage you to meditate and ask your higher self for the dharmic answer that is in line with your true self. **C**

Dr. Toni Galardi is an author, licensed psychotherapist, professional speaker, astrologer, and life transitions strategist and is available for consult by phone or Skype. Have a question for The LifeQuake Doctor? You can reach her through her website, www.lifequake.net or at DrToni@drtonigalardi.com, or at 310-890-6832.



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CESS TIONS:

An Overview



rocess addictions, also called behavioral addictions, constitute a group of disorders that are characterized by an inability to resist an urge to engage in a particular activity. These activities include gambling, sex, shopping/spending, Internet utilization, Internet and video gaming activities, eating disorders, and possibly tanning (Grant, Kim, & Odlaug, 2009; Karim & Chaudhri, 2012; Warthan, Uchida, & Wagner, 2005). They share some significant commonalities with substance use disorders, some of which include the experience of anxiety or excitement preceding the activity and pleasure during the activity (Grant, Potenza, Weinstein, & Gorelick, 2010). The American Society of Addiction Medicine (ASAM) recognizes process addictions in its formal addiction definition as follows:

“The understanding of process addictions as a group is at its infancy.”

Addiction is a primary, chronic disease of brain reward, motivation, memory, and related circuitry. Dysfunction in these circuits leads to characteristic biological, psychological, social, and spiritual manifestations. This is reflected in an individual

pathologically pursuing reward and/or relief by substance use and other behaviors [emphasis added] (2011).

Before proceeding further it is helpful to review what is known and not known regarding process addictions:

- There is a lot more known about substance use disorders than process addictions.
- Gambling disorder is the best understood process addiction.
- There is evidence for a variety of neurotransmitters involved.
- Like substance use disorders, process addictions make use of mesolimbic and mesocortical neural pathways.
- Parkinson's disease provides an interesting lens through which to study at least some of the process addictions.
- There are a variety of treatment modalities for process addictions.

It is not an understatement to say that the understanding of process addictions as a group is at its infancy. In fact, it is not clear whether they constitute a real grouping. In the DSM-5 they are separated into a variety of different sections. For example, binge eating disorder is under eating disorders, kleptomania is in impulse control disorders, Internet gaming disorder in Section III—which means it is still being studied to determine if it is a true disorder—and gambling disorder is grouped with the substance use disorders, which makes it the only disorder so grouped. Nevertheless, there are sufficient similarities on clinical and neurochemical grounds that suggest a common etiology.

Clinical Themes

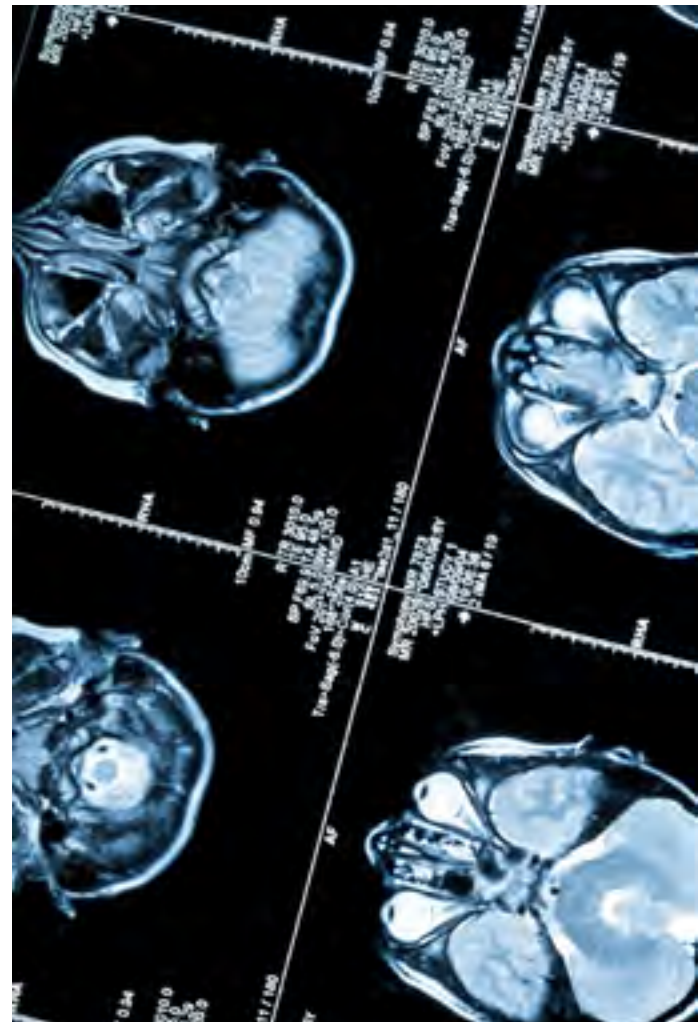
Shared characteristics of these disorders include continued participation in the behavior despite adverse consequences, diminished control, cravings, and a hedonic quality during the performance of the behavior. Other clinical findings that are similar to substance use disorders include adolescent- or young-adult-onset, chronic relapsing patterns, a significant spontaneous remission rate,

tolerance, and a dysphoric state when abstaining. However, there is no evidence of physiologic withdrawal symptoms.

An interesting clinical phenomenon is “telescoping,” a term that refers to an accelerated progression of addictive disorder when the onset occurs later in life. This has been observed in women with gambling disorder when comparing the progression of their disease to men. Interestingly, it has also been described in alcoholism and other drugs such as cannabis, opioids, and cocaine. However, this finding was not confirmed in a recent study possibly due to the observation that younger cohorts are initiating drinking earlier in life.

Neuroanatomy and Neurochemistry

Gambling disorder has the most robust literature base of the process addictions at the present time, and therefore it is a useful model from which to study the remaining process addictions with respect to neurobiology. Although there are a variety of neurotransmitters implicated, the role of dopamine appears central to the process. This neurotransmitter is released in response to the



exposure to addictive drugs in certain parts of the brain to produce euphoria or a reward. Similarly, it is released in those with gambling disorder as function of a reward expectation and gambling severity, but not necessarily with the task of gambling itself.

There is an interesting clinical phenomenon that has been recognized with respect to dopamine. Some patients with Parkinson's disease or restless legs syndrome—and who are being treated with dopamine agonist medications, especially those that stimulate the D2 and D3 receptor subtypes—develop a variety of process addictions even if they have not exhibited those behaviors in the past. These include gambling, hypersexuality, binge eating, compulsive shopping/spending, skin picking, and pathological Internet use. This is additional evidence of the importance of the role of dopamine. Interestingly however, investigators have observed that both dopamine agonists and antagonists have been linked to gambling behaviors. Other likely neurotransmitter candidates include glutamate (compulsiveness and cognitive inflexibility), endogenous opioids (pleasure and

urges), serotonin (impulse control), norepinephrine (arousal and excitement), and cortisol (stress).

The mesocortical and mesolimbic circuits, pathways that mediate processes involved in substance use disorders, also appear to be central to the process of repetitive behaviors in process addictions. These circuits include structures that mediate reward (ventral tegmental area and nucleus accumbens), memory (amygdala and hippocampus), coordination of behavior and movement (substantia nigra and dorsal striatum) and executive function (prefrontal cortex). These pathways can be “hijacked” by addictive drugs and presumably by impulsive or addictive behaviors as well.

Psychological Treatment

The evidence base for treatment for various process addictions ranges from clinical trials to case reports with an emphasis on the latter. Cognitive behavioral therapy (CBT) has shown promise for gambling disorder. This therapy specifically targets the cognitive distortions associated with a disorder. With respect to gambling, the patient is





taught to restructure such distortions as the near-miss fallacy, gambler's fallacy, and chasing one's losses as well as other superstitions such as the illusion of control over random events and the value of talismans such as lucky numbers, colors or articles of clothing. Yet another technique that is being increasingly used to treat gambling disorder is mindfulness.

CBT has also shown promise for the treatment of compulsive buying, sexual addiction, and binge eating disorder. Its evidence is limited to case reports in the treatment of Internet addiction and kleptomania.

Medication-Assisted Treatment

Although there are no medications approved by the Food and Drug Administration (FDA) for the treatment of any process addictions, there are a variety of medications used "off label." Randomized clinical trials exist that support the use of the opioid antagonists naltrexone and

nalmefene for the treatment of gambling disorder. At present this class of drugs would be considered first line therapy, especially for those with a family history of alcoholism, co-occurring substance use disorder or particularly intense gambling urges. Some additional data supported medications to treat gambling are N-Acetyl Cysteine, a glutamate modulator; fluvoxamine, a selective serotonin reuptake inhibitor (SSRI); carbamazepine, a mood stabilizer; lithium, for those with bipolar disorder and gambling disorder; and amantadine, a medication used to treat Parkinson's disease.

Bullock and Potenza (2012) published an excellent review article summarizing the clinical trials of medications studied

to date. They also provide an algorithm to guide the treatment of those with gambling disorder. Those who are reluctant to try medications could attempt a trial of N-Acetyl Cysteine. If an individual is experiencing urges or cravings to gamble or has a co-occurring substance use disorder, consideration of an opioid antagonist is appropriate. An SSRI trial is reasonable if the patient is experiencing anxiety or depression. If they are experiencing mania or hypomania, lithium is an excellent adjunct.

Other process addictions do not have the strength of evidence to support them with the same degree of confidence. This is primarily due to small sample sizes, placebo response rate, and dropout rates. However, some evidence exists although in some cases it is limited to case reports. The following is a list of disorders matched with medications that has shown a potential for success:

- Trichotillomania (naltrexone)
- Hypersexuality (naltrexone)

- Kleptomania (naltrexone)
- Compulsive shopping and spending (citalopram)
- Hoarding (paroxetine)
- Binge eating (topiramate, orlistat, zonisamide, atomoxetine)
- Internet gaming (escitalopram)

Who's at Risk?

There are many risk factors to be considered in determining those most at risk for developing a process addiction problem. An existing substance abuse problem is often found with those suffering from pathological gambling, sexual addiction or another process addiction (Bourget, Ward, & Gagne, 2003). Other factors may be trauma, preexisting psychiatric issues (Petry, 2006), poverty, age, gender, and poor impulse control.

A preexisting substance abuse problem is by far the number one correlate with people suffering from a process addiction. This is not to say that one causes the other, but to point out that many sufferers of say, disordered gambling or sexual addiction also will present with another addiction problem. Neglect and abuse issues in childhood are linked to negative life experiences as adults that in turn may include addiction issues (Moore & Jadlos, 2002). Gambling as a means out of poverty can lead to a disordered gambling problem (Welte, Barnes, Wiczorek, Tidwell, & Parker, 2004). Young males are more likely to develop a disordered gambling problem as opposed to young females, but that changes as people age; in older adults it is the female who is more likely to experience problems with disordered gambling (McCormack, Jackson, & Thomas, 2003) or shopping and spending money.

Conclusion

Although there is still a lot left to be learned regarding process addictions, it seems clear that there are many similarities to substance use disorders. Congruencies in natural history, clinical characteristics, neurochemistry, and neuroanatomy argue for a common source for all. A comprehensive treatment program that offers psychological and medication interventions would intuitively bring about the best outcome, although for many of these disorders there is no evidence to prove that assertion. A variety of medication-assisted treatment strategies is helping us understand the relevant neurotransmitters and an understanding of the underlying neurobiology helps us develop new medications. **C**

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WHAT'S NEW IN

PROBLEM GAMBLING?

■
Mark Griffiths, PhD

In many areas of the world, gambling has become a popular activity. Almost all national surveys into gambling have concluded that most people have gambled at some point in their lives, but that most participants gamble infrequently. The introduction of national lotteries, the proliferation of slot machines, the expansion of casinos, and the introduction of new media in which to gamble—such as Internet, mobile phone, and interactive television gambling as well as gambling via social networking sites—has greatly increased the accessibility and popularity of gambling worldwide, and as a result, the number of people seeking assistance for gambling-related problems. Commissions and official government reviews in a number of countries including the United States, United Kingdom, Australia, and New Zealand have all concluded that increased gambling availability has led to an increase in problem gambling.

Estimates of the number of problem gamblers vary from country to country, but most countries that have carried out national prevalence surveys suggest around 0.5 to 2 percent of individuals have a gambling problem. These surveys also indicate that problem gambling is at least twice as common among males as it is among females, and that those with poor education are more likely to be problem gamblers. In May 2013, the new criteria for problem gambling (see sidebar on page 48) were published in the fifth edition of the *Diagnostic and Statistical Manual for Mental Disorders* (DSM-5), and for the very first time, problem gambling was included in the section “Substance-Related and Addictive Disorders” rather than in the section on impulse control disorders. Although most of us in the field had been conceptualizing extreme problem gambling as an addiction for many years, this was arguably the first time that an established medical body had described it as such. But what else is “new” in the gambling studies field? The remainder of this article

looks at some of the developing trends and issues.

Gambling Industry Innovation

Researchers and legislators alike appear to be constantly playing “catch-up” when it comes to continuing gambling industry innovation. Most of the rapidly shifting trends in gambling are due to technological innovation. Many of the trends outlined in this article may have direct or indirect implications for the gaming industry, particularly as some of these trends may be changing the risk factors associated with problem gambling that players in the future may face. The fundamental issues surrounding gaming operators’ commitment to social responsibility practices remain the same, but with increased technological access, gaming operators may have to think about which groups of people are targeted in terms of minimizing harm. Work and leisure more generally have become increasingly technologized and remote for both adults and children. Activities that were once done in a dedicated external environment, such as an amusement arcade or cinema, can now be done in the home and/or workplace. This has led to “cocooning,” where a majority of activities can be done without ever having to leave the home and/or the work desk. Paradoxically, this cultural shift in increased technology has also led to an increase in leisure on the move (e.g., mobile gaming) that again may have implications for the psychosocial impact of gambling.

Technology Convergence and Gambling

One very salient trend is that technology hardware is becoming increasingly convergent (e.g., internet access via smartphones and interactive television) and there is increasing multimedia integration such as gaming via social networking sites (King, Delfabbro, & Griffiths, 2014). As a consequence, people of all ages are spending more time interacting with technology in the form of internet use; playing videogames, watching interactive television, mobile phone use, social networking, listening to digital radio via MP3 players, etc. In

addition to convergent hardware, there is also convergent content. This includes some forms of gambling including video games with gambling elements, online penny auctions that have gambling elements, and television programming with gambling-like elements (King, Delfabbro, & Griffiths, 2014).

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At present, there are thousands of online gambling sites worldwide that enable players to gamble in traditional games of chance like poker and blackjack, as well as place bets on the outcomes of sports, racing, and other events (Kuss & Griffiths, 2012). Recently, there have been debates as to whether some types of online games should be regarded as forms of gambling, in particular those games in which the player can win or lose points that can be transferred into real life currency. It is still unclear whether video gaming activities that blend skill and chance elements should be strictly classified as “gambling.” Griffiths et al. (2014) reported that there are online video game tournaments in which players are being paid “per kill” in the game. The fact that users can make money by playing a video game has raised concerns that these games may be a contemporary form of gambling. Whilst these games are largely skill-based, there are some similarities between paid online video games and online poker sites. Here, players pay a monthly subscription fee to play the game online, and in return are able to win jackpots, prizes, and awards at random intervals, regardless of the player’s skill level or preferred difficulty level of the game. Much of these new gambling-like activities remain little researched and blur the boundaries between gambling and gaming.

Gambling via Social Networking Sites

The launch of the first gambling for money game, *Bingo Friendly*, on Facebook in August 2012, received worldwide media interest and most gaming operators are now watching closely to see whether the move from social gaming to social gambling will be profitable. Gambling-type games are popular on Facebook; the October 2013 monthly figures for the most popular games played on Facebook showed that *Texas Hold ‘Em Poker* was one of the most popular games with twenty-four million players worldwide, down from thirty-four million the year before (Griffiths, 2013a). Online gambling operators and software developers are positioning themselves for entry into the social gaming market, and vice-versa. Social networking games provide pleasure, accomplishment, and friendship. Even when games do not involve money (e.g., playing poker for points on Facebook), it introduces players, oftentimes youth, to the principles and excitement of gambling. One of the key psychological ingredients in both gambling on casino machines and social gaming is the use of operant conditioning and random reinforcement schedules.

Getting rewards every time someone gambles or plays a game leads to people becoming bored quickly. Therefore, small unpredictable rewards leads to highly engaged and repetitive behavior for those players. In a minority of cases, this may lead to addiction. Both gambling operators and social gaming developers use intermittent and unpredictable rewards to facilitate habitual behavior (i.e., get repeat custom). Social networking sites have the potential to normalize gambling behavior as part of the consumption patterns of a nongambling leisure activity. This may change social understandings of the role of gambling among young people. In these situations, there is no money changing hands, but it again raises questions about whether gambling with virtual money encourages positive attitudes towards gambling in people, and young people particularly. For instance, does

gambling with virtual money lead to an increased prevalence of actual gambling? Today's youth are more tech-savvy, have no technophobia, and very trusting of these new technologies. Facebook has changed the way people and possibly gamblers are playing games. Empirically, we know almost nothing about the psychosocial impact of gambling via social networking sites although research suggests the playing of free games among adolescents is one of the risk factors for both the uptake of real gambling and problem gambling (Griffiths et al., 2014).

The Rise of the "Screenager"

Young people's use of technology, the so called "screenagers" and "digital natives," has increased greatly over the last two decades and a significant proportion of daily time is spent in front of various screen interfaces, most notably videogames, mobile phones, and the Internet. These screenagers have never known a world without the internet, mobile phones, and interactive television, and are therefore very trusting of these new technologies. For many of these young people, their first gambling experiences may come not in a traditional offline environment, but via the Internet, mobile phone or interactive television (Griffiths et al., 2014). This is an issue for both offline operators—as they will need to think about displacement effects and whether they will lose custom through newer consumers preferring online gambling over traditional gambling—and online operators, who will need to make sure their games and products are not accessed by minors and/or that they are not directly advertising to minors.

Technology has also changed the way that society views social and asocial activities. Although many people's interactions with technology are asocial, such as a single person engaging in some kind of screen-based activity, many of the activities carried could arguably be described as social activities, like playing and chatting to others in an online video game or during online gambling on bingo or poker, chatting via Twitter or other social networking sites,

etc. Not only do gamblers feel less embarrassed and guilty when they lose online, as they feel more disinhibited and anonymous because no one can actually see them, they may also be also be adopting another social persona (e.g., someone of a different age, gender or nationality), something that has shown to be a risk factor for problem gambling in online poker players (Griffiths, Parke, Wood, & Rigbye, 2010).



Feminization of Gambling

Another key demographic group playing a role in the way gambling is changing is that of women. Apart from gambling on bingo and lotteries, gambling has traditionally been a male domain. However, the newer, more technological forms of gambling are gender-neutral and what we seem to be witnessing more and more is the feminization of gambling. The most obvious example is online bingo, where online gaming companies around the world are now actively targeting females to get online, socialize, and gamble. Additionally, there are many operators around the world, including those in the lottery sector and television companies looking for other revenue streams, that are targeting women via their online instant game sites. Although males still heavily outnumber females in both online and offline gambling (Kuss & Griffiths, 2012), it is likely that the prevalence of female gambling participation—and as a consequence problem gambling—will increase over the next decade.



New Trends in Gambling

One of the key drivers behind the increased numbers of people gambling online and using social networking sites is the rise of mobile gambling and gaming. Compared to Internet gambling, mobile gambling is still a relatively untapped area, but the functional capabilities of mobile phones and other mobile devices are improving all the time (Griffiths, 2013b). There are now hundreds of gambling companies

that provide casino-style games to be downloaded onto the gambler's smartphone or mobile device. This will have implications for the psychosocial impact of gambling and will need monitoring. Like online gambling, mobile gaming has the capacity to completely change the way people think about gambling and betting. Mobile phones provide the convenience of making bets or gambling from wherever the person is, even if they are on the move. This will aid various sectors within the gaming industry—particularly sports betting and the "in-play" markets (see next section).

One of the most noticeable changes in gambling over the last two years or so has been the large increase of "in-play" sports betting (Griffiths, 2012a). Gamblers can now typically bet on over

PROBLEM GAMBLING

sixty in-play markets while watching a sports event, such as a soccer match. For instance, during a soccer game, gamblers can bet on who is going to score the first goal, what the score will be after thirty minutes of play, how many yellow cards will be given during the game, and/or in what minute of the second half the first free kick will be awarded. A number of factors have helped facilitate the rise of in-play betting including the increasing use of mobile devices and a marked shift in gamblers wanting instant 24/7 gratification when they bet or gamble (Griffiths, 2012a). Live betting is going to become a critical activity in the success of the future online and mobile gambling markets.

The most salient implication of in-play sports betting is that it has taken what was traditionally a discontinuous form of gambling—where an individual makes one bet every Saturday on the result of the game—to one where an individual can gamble again, and again, and again. Gaming operators have quickly

capitalized on the increasing amount of televised sports. In contemporary society, where there is a live sporting event, there will always be a betting consumer. In-play betting companies have both catered for the natural betting demand and introduced new gamblers in the process. If the reward for gambling only happens once or twice a week, it is completely impossible to develop problems and/or become addicted (Griffiths & Auer, 2013). In-play has changed that because there are soccer matches on almost every day of the week, resulting in a daily, over two-hour period of betting, seven days a week. Based on the relationship between event duration, event frequency, bet frequency, and payout interval, empirical research has consistently shown that games that offer a fast, arousing span of play, frequent wins, and the opportunity for rapid replay are those most frequently cited as being associated with problem gambling (Griffiths & Auer, 2013).



The rise of online poker has been one of the success stories for the online gaming industry. This rise has also led to more research in this area including some that suggests a different way of viewing problem gambling. For instance, research has suggested that online poker may be producing a new type of problem gambler where the main negative consequence is loss of time rather than loss of money (McCormack & Griffiths, 2012). This research has identified a group of problem gamblers who, on the whole, win more money than they lose. However, they may be spending excessive amounts of time, such as twelve to fourteen hours a day, doing this. This could have implications for problem gambling criteria in the future (i.e., there may be more criteria relating to the consequences of time conflicts as opposed to financial consequences). Other new types of problem gamblers may be those who gamble via social networking sites and/or those who gamble via their mobile devices.

Behavioral Tracking Data and Social Responsibility Tools

New technologies in the form of behavioral tracking have helped online gambling companies keep track of player movement by noting what games the customer is playing, the time spent playing, the denomination of the gambles made, and the number of wins and losses, among other things. Although such technologies can potentially be used to exploit gamblers (e.g., targeting the heaviest spenders with direct marketing promotions to gamble even more), such technologies can also be used to help gamblers who may have difficulties stopping and/or limiting their gambling behavior

DSM-5 DIAGNOSTIC CRITERIA FOR GAMBLING DISORDER

(American Psychiatric Association, 2013)

A. Persistent and recurrent problematic gambling behavior leading to clinically significant impairment or distress, as indicated by the individual exhibiting four (or more) of the following in a twelve-month period:

1. Needs to gamble with increasing amounts of money in order to achieve the desired excitement
2. Is restless or irritable when attempting to cut down or stop gambling
3. Has made repeated unsuccessful efforts to control, cut back or stop gambling
4. Is often preoccupied with gambling (e.g., having persistent thoughts of reliving past gambling experiences, handicapping or planning the next venture, thinking of ways to get money with which to gamble)
5. Often gambles when feeling distressed (e.g., helpless, guilty, anxious, depressed)
6. After losing money gambling, often returns another day to get even (“chasing” one’s losses)
7. Lies to conceal the extent of involvement with gambling
8. Has jeopardized or lost a significant relationship, job or educational or career opportunity because of gambling
9. Relies on others to provide money to relieve desperate financial situations caused by gambling

B. The gambling behavior is not better explained by a manic episode.

(Griffiths & Whitty, 2010). Over the past few years, innovative social responsibility tools that track player behavior with the aim of preventing problem gambling have been developed. These new tools are providing insights about problematic gambling behavior that in turn may lead to new avenues for future research in the area. The companies who have developed these tools claim that they can detect problematic gambling behavior through analysis of behavioral tracking data (Delfabbro, King, & Griffiths, 2012).

If problem gambling can be detected online via observational tracking data, it suggests that there are identifiable behaviors associated with online problem gambling. Given that almost all of the current validated problem gambling screens diagnose problem gambling based on many of the consequences of problem gambling—for example, compromising job, education, hobbies and/or relationship because of gambling; committing criminal acts to fund gambling behavior; lying to family and friends about the extent of gambling, etc.—behavioral tracking data appears to suggest that problem gambling can be identified without the need to assess the negative psychosocial consequences of problem gambling (Griffiths & Whitty, 2010).

Online Help and Therapy

Finally, one very notable trend that is likely to become more important is the use of technology in the area of help, guidance, and treatment of problem gamblers. Socially responsible online gambling sites typically feature links to relevant gambling help and awareness sites (Griffiths, 2012b). Although there are some disadvantages to online therapy for problem gamblers—lack of nonverbal information for the therapist, the therapist not being totally certain of the client's identity, issues surrounding which jurisdiction the therapist is licensed to practice, technological failures, the client's severity of problem, client referral problems—there are many advantages for the problem gambler including convenience, cost-effectiveness, helping overcome social stigma, and

helping overcome barriers that may prevent people from seeking face-to-face help, such as feeling stigmatized, being disabled, being geographically isolated, and/or being in an institution (Griffiths, 2010). Additionally, many of the generic factors that make the Internet attractive for gambling online are the very same factors that may attract those with gambling problems to seek help online: ease of accessibility, affordability, anonymity, convenience, and disinhibition, among other things. Additionally, the screenagers of today are the gamblers of tomorrow, and this is the first generation that have lived out their lives as much online as offline and are naturally trusting of the Internet.

Conclusions

Obviously the salient trends highlighted in this brief article are somewhat subjective and based on my own expertise within the gambling studies field. However, these are all areas that gamblers and the gaming industry should have a natural interest in knowing more about—hopefully as a way of enhancing the customer experience and minimizing customer harm. The examples of convergent gaming in this article highlight that commercial operators always appear to exploit new market opportunities in emerging media and that they are often two steps ahead of legislation. All of the issues and trends reported here directly affect gambling practices and deserve further debate and empirical research. Future research can aid governments in devising relevant and pragmatic social policy responses to the problem of remote forms of gambling (e.g., Internet gambling, mobile gambling, gambling via social networking sites, gambling via interactive television). These responses may involve various strategies, including monitoring gambling advertising on the Internet and examining how these messages may affect potential gamblers, developing a research agenda focused on online gambling, and supporting health authorities in their campaigns to reduce the adoption and maintenance of gambling behavior among individuals. Ultimately, legislators and policy makers are the ones who decide to what extent

gamblers should be protected from potentially harmful activities like interactive online gambling, and to impose measures that do not compromise the consensual experiences of those that want to gamble. **C**

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THE
FOOD
ISSUES
EATING
US ALIVE

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Any given month in America, between six and fifteen million people binge eat out of control, according to the National Institute of Mental Health (n.d.). Yet millions never get help or seek treatment. If they did, they would find our community, along with doctors, scientists, researchers, and therapists who confront overeating, though we are sometimes divided on what to do. What causes this epidemic? Is the problem biological or psychological? Are there answers in a matter of willpower or hardwiring in the brain?

Meanwhile, as we sort through the questions, food manufacturers keep introducing new foods designed to be irresistible in taste and texture, with synthetic flavor enhancers that stoke and instill cravings. In fact, the *New York Times* did an extensive report on this just a year ago titled “The Extraordinary Science of Addictive Junk Food” (Moss, 2013). People keep overeating, gaining weight, and obsessing about food until it ruins too many lives.

Today, one in three adults (nearly forty million people) is considered clinically obese, along with one in six kids (NIDDK, 2014). Additionally, twenty-four million Americans are afflicted by type 2 diabetes, often caused by poor diet, with another seventy-nine million people having prediabetes (CDC, 2014). It doesn’t make sense, does it? Food is something every person needs to live, like air and sleep. How can you be addicted to something essential for life?

The facts are undeniable: too many people spend their days and nights obsessing about food and consuming it in voluminous amounts. Too many others don’t necessarily obsess, but find themselves



FOOD ADDICTION

in situations that spiral out of control. They start snacking on chips and end up downing the whole bag. A small bowl of ice cream turns into emptying the container. They go into debt or spend their last dollars on desserts or bread and high-fat food for a fix one day, and a new diet plan or program and exercise equipment the next. Life is being eaten away. Food is costing us health, money, relationships, vocation, hobbies, and peace. How did we get to this place of such dysfunction with food and the resulting weight? How can we, as the professionals, help?

Understanding the Issues

A starting place is in recognizing that the brain can be hardwired to crave certain foods, just as an alcoholic craves a drink and a drug addict craves a fix.

It's tempting, even in our field, to think the problem is emotional and a person who overeats just needs to use more self-control and willpower, and needs to work out and exercise, or go on a diet and substitute carrot sticks and celery for cookies and ice cream, or eat less and in moderation. Every day another diet book, program or fitness guru tries to convince us of these things, as well as how much better life will be when we're skinny. The reality is that such advice couldn't be more disastrous.

For the person whose brain is hardwired to be triggered by certain foods, this over-the-counter advice lasts but a moment and the problem remains unsolved. For the person who falls prey to foods designed to be addictive, these mantras don't even register—a taste can trigger an episode of overeating and the shame of it makes this person turn to food for comfort, and the food triggers more episodes, and on the cycle goes.

The Science on Addiction

The reasons people pig out, overeat, and find themselves addicted to foods aren't because they're fat, stupid, lazy, indulgent, greedy or have no willpower or pride. In fact, it takes a lot of work, creativity, and intelligence to hide overeating, binges, food abuse, and food addiction from a world that frowns on overweight bodies and links overeating to obesity.

The bigger picture is this:

- Chemical properties of certain foods, coupled with faulty brain wiring, can contribute to overeating.
- It can be determined whether a person who overeats has a trigger issue controlled by avoiding certain foods, or an addiction to those foods and a need for a more intense course for recovery.
- There are ways to eat that allow a person to make peace with food and lose weight and find wholeness.
- A food plan can be followed and weight lost, but there is a lot of emotional and spiritual work to do to find true freedom from a food trigger or addiction—the reasons that compel overeating and an obsession with food or its effects—so a whole mind, body, and spirit approach to help and treatment is essential.



Professor Bart Hoebel and his colleagues at Princeton University's Neuroscience Institute made some fascinating discoveries in a series of studies on food addiction, which was reported in *Neuroscience & Behavioral Reviews* (2008). They found in studies with rats that trigger foods, sugar in particular, do have long-lasting effects in the brain of a sugar-addict just as alcohol has in the brain of an alcoholic and drugs in the brain of a drug-addict.

Your clients aren't rats, but they can be hardwired like them to be hooked on sugar just like cocaine. So just as rats showed signs of withdrawal when researchers took away their sugar, people trying to quit bingeing on desserts and snacks fight the same battle as those trying to kick an alcohol or drug habit. Take away their trigger foods and the feel-good chemicals in their brains go down. Fear and anxiousness increase. Withdrawal symptoms appear: sluggishness, headaches, irritability, rapidly changing mood swings, anxiety, sadness, anger, cravings, and sleep disturbance.

To deal with it all, just like drug and alcohol addicts taking another hit or drink to keep the symptoms at bay, the food addict goes for another bite, another carton or container, another binge.

Hoebel's rats showed an anxiousness and desperation to consume more of the sugary foods on which they were hooked. After bingeing on foods rich in sugar and fat for a two-month period, the addiction became so strong that when presented with healthier foods, the only choice for them was to go hungry before eating anything without sugar and fat; the rats would starve themselves rather than free themselves from the high they got on sugar and fat.

Food addicts do the same. Comfort food becomes just that in their minds: a source of relief and release . . . at least until the

next fix on food is needed, and that's quite soon because of the physical craving, emotional shame, and spiritual emptiness that the addict seeks to comfort and soothe.

Think how much junk food, made up mostly of sugar and fat or both, debilitates us. Sugar and fat can actually desensitize the reward pathway in our brains so that we need more and more in order to experience the same happy feeling as before. Nothing else, including healthy foods, satisfies—not for the rats, not for the food and sugar addict. Yesterday, it may have only taken one candy bar to boost their mood. Today, it takes two candy bars to bring back the happy.

It is indeed a rat race, this experience of a true chemically-driven craving.

This is Why Diets Don't Work

So the problem is when addicts' brains are hard-wired for addiction, addicts can never eat enough of their trigger foods to get that happy feeling they want. Each binge sets in motion an uncontrollable chemical process that has a feedback loop. Like a hamster on a wheel, the food addict wants to eat even more sugar or carbohydrates or high-fat foods. It's a vicious circle: eating the trigger foods stimulates the pancreas to release insulin, which decreases the concentration of amino acids, which manufactures serotonin in the bloodstream, which causes a drop in blood sugar level, which results in feelings of weakness, hunger, headaches, and trembling. Every drop in blood sugar for the food addict triggers eating more to offset the symptoms—and round and round the cycle goes.

While many people who overeat can try the latest diet on the market and find some success with temporary weight loss, it doesn't last. The person with a brain hard-wired to be addicted to certain foods, such as sugar and white flour, can start out deciding to live completely without the carbs, sweets or fat. Then, because that's hard, they stray a bit. They take back a little bit of bread, maybe add some butter to the vegetables, a drop of cream to the coffee. That's all it takes to be off to the races again, running with whatever tastes good.

You see, the diet was never the real issue to start. There is an addiction, and that means there are trigger foods to be avoided, just like wine or liquor for the alcoholic—and there is mind and spirit work to do too.

Treatment We Can Agree Upon

It's essential for an addictions model of treatment to address not just the body, but the emotions and spirit too. Here's where we, as counselors and therapists, can best serve clients with eating issues, whether those issues are just being triggered to binge once in a while or in full-blown addiction where the obsession with food and weight is consuming and ruining the addict's life.

However, there needs to be a greater understanding of food addiction by our clients and ourselves. We live in a culture where loss of control with food is fairly common, where people make light of it, where the skits on *Saturday Night Live* and in movies show someone drowning their troubles in pints of ice cream and piles of candy bars, or the overweight actor goes crazy, going for laughs, in a binge scene—and we laugh along.

This is no longer a laughing matter, no longer a matter where we give in to the temptation to begin treatment with a diet and fixing solely upon the food.



HOW DO YOU KNOW WHEN FOOD IS AN ISSUE?



What separates an actual food addiction from an occasional incident? This may seem impossible to determine because, unlike addictions to alcohol or drugs that keep other addicts abusing a substance, people can't just stop using food. Everybody needs food to live, and most everybody overeats sometimes.

However, you can know when that problem is unhealthy or debilitating. A deciding factor is the level of obsessive behavior: incidents happening again and again, the constant thoughts of when one can binge again or hide a binge or stop one by dieting—all this spinning over and over, through all these cycles with food.

The Yale Food Addiction Scale online self-test can help you see immediately if your clients' relationship with food has become dangerous. Go to <http://www.yaleruddcenter.org/resources/upload/docs/what/addiction/FoodAddictionScale09.pdf>. If your clients are answering "yes" to even one or two of the questions, their relationship with food is dysfunctional.



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We're not nutritionists and remember, the diet is not the issue. There needs to be a change of thinking and a change of heart for the change in eating and weight to occur.

To Treat the Body

Of course the temptation is to focus first on the food. While a client doesn't need a diet, they do need a food plan that's structured and measured, something a nutritionist who understands addiction can help develop. The plan isn't a diet because it's not about restricting, though it does involve some abstaining from foods that trigger just as a plan for the alcoholic calls for keeping away from the liquor. The difference with food is you have to have food to live—a key on a healthy food plan is being sure clients get what's needed and aren't left feeling so deprived and hungry that they reach for a trigger food or turn again to binges.

Most food addiction treatment programs start out with a sugar- and refined-carbohydrate-free plan—as these are the most common triggers—where you weigh and measure foods at three meals with one or two snacks a day. This is so important because a client probably has a fairly distorted view of what a normal portion is. While some people can eat cleanly without weighing and measuring, your client may need to stick with the scales and cups at the start. Look for the plan to

- satisfy hunger. It's important to have a plan that satisfies clients and doesn't leave them feeling hungry. The guiding principle is there needs to be enough to eat, but not too much.

You want a food plan that clients can live with for the rest of their lives, meaning it can't be a restrictive weight-loss plan. Ironically, when they eat well, they get to a weight that's right.

There's not one way to eat trigger-free. A nutritionist well-versed in food addiction treatment is preferable for making a plan. If a client gets a plan from a nutritionist who is not an addiction specialist, you can advise getting it adjusted by someone well-versed in overeating issues, maybe someone overcoming bingeing in recovery. This is important because a nutritionist may see nothing wrong with a plan including sugar-free foods. But even a taste of sweet, though it isn't sugar *per se* can trigger a food addict to binge, and someone understanding addictions can advise better substitutions.

Good advice to offer here is this: learn the language of food, such as



the names for sugar and the ingredients that trigger binges. Read labels. Know appropriate portion sizes, including how to easily eyeball right portions.

As a food plan is developed, it's an important step to help a client see that if they fail to plan, they plan to fail. Thinking through situations, and thinking ahead is a huge step toward change. How can they expect to manage eating out when they can't control the food offered and at what time? How can they get through social events centering on food?

This is part of not just making, but keeping a food plan, preparing one- self, strapping on that seatbelt, driving defensively through the choices and changes along the way, and strengthening the mind and spirit to help when the body and emotions feel out of control. This isn't an issue of willpower, not a matter of looking for determination to stick to a diet. This is positioning the self to make good choices, plan the changes to make,



- be clear and structured. There needs to be boundaries with food, a beginning and end to eating meals. Clients need to know which foods are good choices and which will trigger them. They will want something clear enough to keep them from overeating, but loose enough to live in a world where they share meals with others without being tied to one thing. They will want to commit to three meals a day and maybe one or two planned snacks, preferably around the same times each day.
- include all the main food groups. That means complex carbohydrates such as fruits; vegetables; whole grains; lean proteins such as fish, poultry, meat, and tofu; fats; and dairy. They will want the foods necessary for health.

relate in a new way to food and eating, and map out the steps needed to avoid the triggers and the behavior to take away from whatever will drag down or set the client back.

To Treat the Mind

Here is where real work begins: to start recognizing what drives clients to eat. What's their first memory of a binge or overeating? Ask them to write down the place, circumstance, what was eaten and where, how they felt afterwards, and what they did. Then have clients write down the next memory, and a next. Is there a pattern? Are there emotional triggers like boredom, frustration, anger, and feeling abandoned, unloved or unattractive? You can begin to deal with each of these emotional keys.

The next step is to help clients recognize and separate the hungers of mood and food. Emotional hunger doesn't notice signs of fullness and isn't satisfied by eating, leaving one feeling ashamed and guilty. It must be fed what is craved and can come on suddenly. Physical hunger, on the other hand, can be satiated without guilt by most any food and grows gradually.

As clients begin to recognize what's driven them to dysfunctionally seek comfort in food in the first place, a range of troubling issues and anxieties can surface. Now you're getting to the heart of things—where walls have been put up or bridges burned, where clients have been stopped, tripped or become stuck, what's kept them isolated or from connecting with others, when they've felt their best or worst or in control or not, and what's made them feel rejected or accepted.

A big help here for the overeaters' low self-worth and self-care is helping them arrest what physician, psychiatrist, and author Daniel G. Amen calls the "ANTS" or "Automatic Negative Thoughts"; the cynical, gloomy, complaining thoughts that come on, one after another, and keep a client from moving forward. These are thoughts that run like a freight train through the mind, looping over again with negativity that can become self-fulfilled prophecies: *They won't like me. I'll never beat this. I always fail. I'll never be more than a mess. I can't do anything right or well.*

The ANTS aren't just bad for a client's mind, but for their spirit. See how mind, body, and spirit treatment must be connected? Angry, unkind, sad, and grumpy thoughts can activate the deep limbic system and make the body feel bad. Muscles tense, the heart beats faster, hands sweat, and a dizzy and off-balance feeling can take over, triggering irritation, frustration, depression, anger, sadness, and despair—any manner of negative thoughts. By the same token, happy, good, hopeful, kind thoughts trigger the brain to release chemicals that cool your limbic system, creating calm, relaxation, and slower and more steady heartbeats and breathing. Dealing with the ANTS will give a client self-acceptance, worth, and peace.

To Treat the Spirit

What the person overcome by food issues is looking for is peace of mind; in body, with food, and in relationships. So

many clients with food issues have harbored their secrets for so long, in such shame, that there are lifetimes of deeper issues to deal with. The self-blame and loathing is so strong it's as though clients are walking around in a movable prison; always bound, never free.

To truly recover, the soul, not just the stomach, needs to get and live clean.

Here's what the addiction model of treatment offers as the best course for change and progress: the prayers and meditations for surrendering to what a person can do and what they can let go of to truly achieve freedom. These prayers not only calm the soul, but build an inner strength. Our most common example is the Serenity Prayer and the Prayer of Saint Francis of Assisi.

Even science acknowledges there is a biology of belief, meaning that faith and the practices of it help the body heal, strengthen, and achieve more vitality. Neuroscientists Andrew Newberg, MD, and Mark Robert Waldman chronicle the effects from a multitude of respected studies in their book *How God Changes Your Brain* (2010): spiritual practice reduces stress; contemplating a loving God curtails anxiety; prayer deepens the capacity for gratitude and increases feelings of security, compassion, and love; meditation has lasting effects on the positive functioning of the brain; and belief in God helps one handle a diagnosis of illness and fare better afterward.

Faith, hope, and love for the self are what ultimately help a client burst free and forward from food issues. Belief in what's good and true empowers the client to love themselves enough to do the work on their emotional past, their confused present, and stick to a food plan. When this happens, clients can finally focus on their goals and relationships more than on food, build a winning support system to get through the hard events, and live free of the mad cycle around the binges. What's been eating them alive is no longer what they chew upon, and we can serve them this freedom by first agreeing on this model of helping the *whole* person, not just a part. 

Rhona Epstein, PsyD, CAC, is a licensed psychologist, certified addictions counselor, and marriage and family therapist in the Philadelphia area. She is also the author of *Food Triggers: End Your Cravings, Eat Well, and Live Better*. For more than twenty-five years, she's led seminars, conferences, and therapeutic workshops to help people overcome food addiction and its underlying issues. She received her doctorate in clinical psychology from Chestnut Hill College, and her master's degree in counseling psychology from Temple University.

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ON SLAYING THE DRAGON:

AN INTERVIEW WITH BILL WHITE

MARK SANDERS, LCSW, CADC

Bill White is known to many of us as a long-tenured addiction professional whose contributions to the field span the arenas of clinical practice, clinical research, and recovery-focused journalism. Bill is an Emeritus Senior Research Consultant at Chestnut Health Systems, past chair of the board of Recovery Communities United, and a volunteer consultant to Faces and Voices of Recovery since its inception in 2001. He has authored more than four hundred articles and monographs—including more than seventy-five articles for *Counselor*—and seventeen books. His contributions to the field have been acknowledged by awards from such organizations as the American Society of Addiction Medicine, the National Association of Addiction Treatment Providers, the American Association for the Treatment of Opioid Dependence, NAADAC: The Association for Addiction Professionals, Harvard

University Medical School, and the Native American Wellbriety Movement.

Bill White is perhaps best known as the author of *Slaying the Dragon: The History of Addiction Treatment and Recovery in America*, which won the Terry McGovern Foundation award for the best book on addiction recovery. A second edition of *Slaying the Dragon* has just been released with thirty-one chapters, 580 pages, and more than 2,500 posted research citations. Before this new edition was released, I interviewed Bill about his work as the historian of our field. This was a particular pleasure for me because of my collaborations with Bill reconstructing the history of addiction recovery among African Americans.

Early Historical Research

Mark Sanders: Bill, how did your interest in the history of the field begin?

Bill White: In 1976, after working in the field for almost a decade, I went back to school to get a master's degree in addiction studies. One of the first things my primary mentor, Dr. Ed Senay, did was hand me a copy of David Musto's *The American Disease*. References to early episodes of addiction treatment within this brilliant history of American drug policy triggered what became a lifelong fascination with the history of addiction treatment and recovery. The initial discovery of early treatment and recovery history also left me feeling cheated. How could I have worked in the field so long and in so many roles without anyone having previously shared this history with me?

Mark Sanders: When did you decide to write a book pulling together all of your historical research?

Bill White: I began collecting books and artifacts on the history of treatment and recovery in the mid-1970s as a hobby and began sharing some of the stories I was discovering through various presentations. The warm and appreciative responses to these stories prompted the thought that perhaps I could one day write the kind of history that I wished someone would have given me when I entered the field. The more concerted research on the book began in 1990, and the writing started in 1994. It

took another four more years to finally send *Slaying the Dragon* to press. Most addiction professionals first learned of the book through a series of articles based on the book that I authored in *Counselor*.

Mark Sanders: How did you come to choose the title of the book?

Bill White: Through my research on the early history of addiction and its treatment, I continually encountered images and references to dragons, snakes, and monsters. References to chasing dragons and slaying dragons have a long history in America's illicit drug culture. These images capture the human species' unrelenting attraction to intoxicants and the near-mythical struggles to escape the clutches of addiction. The title was intended to convey that this is a book filled with the stories of people chasing dragons, being devoured by dragons, and taming or slaying dragons.

Mark Sanders: The field is currently focused on the science of addiction, which requires us to look toward new discoveries and innovations that can impact the future of addiction treatment. What are the reasons that you, as an historian, would have us look back?

Bill White: There is a long-cherished belief among historians that, if we sat at history's feet and truly listened to her stories, then perhaps she would not have to keep repeating herself. I am not interested in history for history's sake; I am interested in the lessons history has to teach us that can inform the decisions we make as professionals, as a field, and as a country. *Slaying the Dragon* is above all a book of stories, but it also explores the meaning of each story within our contemporary context. *Dragon* respects the evolving science, but it also casts a critical eye on purported innovations that wrap themselves in the mantle of science. We should never forget that some of the most abusive, harmful interventions—from mandatory sterilizations to lethal detoxification protocol to prefrontal lobotomies—were wrapped in the mantle of science during the years of their introduction.

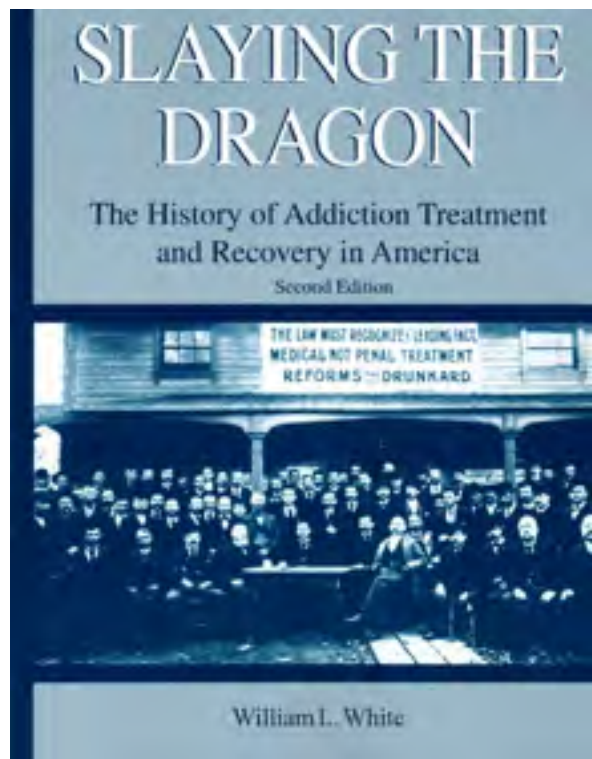


Mark Sanders: The first edition of *Slaying the Dragon* was a popular text in many addiction counselor training programs. What do you think was its main attraction?

Bill White: Well, it was the first comprehensive history of addiction treatment and the book was very affordable, but I also think the book was embraced because of its readability and practicality. It was a history written through the eyes and sensitivities of an addiction professional with a particular focus on recovery as an organizing motif throughout the book. I think the addiction studies leaders also wanted to place a book in the hands of their students that could serve them as a reference text for years to come. I wanted a book that would welcome people into the field and tell them the stories of those who had gone before, and I think the book achieved that.

Mark Sanders: What surprised you most about the feedback you received about the book?

Bill White: I had hopes that the book would reach a large audience of addiction professionals, but I had underestimated the personal impact the book would have. Many addiction professionals and many people in recovery found their own stories reflected in the pages of *Slaying the*



Dragon. Their letters and emails were a source of great inspiration to me during those times when my energy would wane in preparation of the new edition.

Mark Sanders: I was surprised to learn that the first edition was translated into Japanese. What was the source of Japan's interest in the history of addiction recovery in America?

Bill White: I started hearing from people in other countries, including Japan, shortly after the publication of *Dragon*. I do not fully understand the popularity of the book in these countries, but it has served as a source of inspiration and guidance. In Japan, for example, the shame historically attached to alcohol and other drug problems is much greater than in the US. The translation of *Slaying the Dragon* and my lectures there seemed to have helped Japan increase momentum for the expansion of addiction treatment and recovery support resources. I vividly remember the look of shock when I first described to Japanese audiences that Americans in recovery from addiction were marching publicly in the streets of American cities to celebrate recovery. That seemed so unthinkable at the time, and yet I recently received images from the latest recovery parades in four

major Japanese cities. I would like to think *Dragon* helped elevate the quality of addiction treatment in Japan and helped incubate a rising Japanese recovery advocacy movement. I hope it has had that same effect in other countries as well.

Profile of the New Edition

Mark Sanders: What changes in the field prompted you to write a new edition of *Slaying the Dragon*?

Bill White: Since publication of the first edition, there has been seminal research by others on some of the earlier periods of history

described in *Dragon*. There were also more than fifteen years of new addiction and recovery research and, of course, the many significant developments within the field that have transpired since 1998. That addiction treatment has gone through significant challenges and changes in the past sixteen years is self-evident, but readers may not appreciate some of the momentous and unprecedented events that have occurred within the larger history of addiction recovery. Such events include the growth and diversification of recovery mutual aid societies, the cultural and political mobilization of people in recovery, the emergence of new grassroots recovery support institutions, the rise of recovery as a potentially new organizing paradigm for national drug policy, and key breakthroughs in recovery research. Pulling together the threads of these developments into new chapters within *Slaying the Dragon* was a work of love.

Mark Sanders: What were the major challenges you faced with the new edition?

Bill White: There were the challenges of reading history close up and separating the essential from the ephemeral. That is

always difficult. There are also so many complexities within the modern era of addiction treatment and recovery that it deserves multiple books, not just a new chapter or two. Awareness of that generated pressure to synthesize the most important developments with as much clarity as I could muster even where the long-term effects of some events were not yet clear.

There was also pressure about space. When *Dragon* was first published, some critics scoffed that few addiction professionals would read a larger than normal size book of more than four hundred pages. While the continued sale of *Dragon* over the next fifteen years defied those predictions, I was still faced with how to add new material to the book without reaching a length that was either too personally daunting to potential readers or prohibitively expensive. Time will tell if I was able to meet that challenge.

I also wanted to tell the story visually in this new edition. That required collecting hundreds and hundreds of photographs and carefully selecting which ones would help the stories I was trying to tell come alive. I think the photos in the second edition add a whole new dimension to the experience of reading the book.

Mark Sanders: In the first edition you wrote extensively about the contributions that peers have made to addiction recovery. Does the new edition elaborate on contributions that peers have made in the last decade?

Bill White: Yes, there is far more information on the growing diversity of recovery mutual aid organizations in the US, including a whole new chapter on the history of Narcotics Anonymous written in collaboration with Chris Budnick and Boyd Pickard. There are also new sections on the growth of recovery homes, schools, and ministries as well as the growth of peer-based recovery support services.

Mark Sanders: Do you have favorite chapters?

Bill White: I like the chapter on the Keeley Institutes and the chapter on Parkside because they so vividly recount

the rise and fall of prominent treatment institutions and are so filled with lessons of considerable import for today's organizations. I think my other favorite chapters are the new chapter on the history of NA and the chapter entitled "The Recovery Revolution" that outlines the new recovery advocacy movement and its historical import.

Personal Reflections

Mark Sanders: For many years, you worked in conducting research studies and interpreting current research for addiction counselors. What has it been like to blend this role with your role as the field's historian?

Bill White: It has been helpful in integrating the perspectives from both history and science. These areas are complementary, but they represent quite different ways of knowing—the knowing of the laboratory and the knowing of collective experience.

Mark Sanders: You have written extensively on the history of addictions treatment in America and recently about the future of addiction treatment in America. That would make you both historian and futurist. How are these areas related?

Bill White: Well, I think the futurist is a far more dangerous role. I have written a few articles predicting trends over the years with the full knowledge

that I may make a fool out of myself through this process. I am on much more solid ground as a historian with files and files of evidence to back up any question about how I know this or that really happened that way. I do think, however, that there is great value in trying to predict trends and formulate plans to address anticipated changes within the field and within the field's operating environment.

Mark Sanders: You have also spoken a great deal about the importance of mentorship. Who have been the most important mentors for your history research? And are you currently preparing others to become historians in the addictions field?

Bill White: I've been very fortunate to have had wonderful mentoring for my historical research. Foremost among these is the Harvard-trained historian Ernie Kurtz, who is best known for his books *Not-God: A History of Alcoholics Anonymous*, *The Spirituality of Imperfection*, and his recently released *Experiencing Spirituality*. Ernie has mentored nearly all of my historical writings either directly or through the principles he taught me about historical research and writing. Other important sources of technical advice and encouragement through the years were Dr. David Musto of Yale and Dr. David Lewis of Brown. I have tried to pass along what I have learned to a new generation of treatment and recovery historians.

Mark Sanders: What is your next major history project?

Bill White: I am currently working with NAADAC on researching the history of addiction counseling and the history of NAADAC. This will be much more focused on addiction counseling, whereas *Slaying the Dragon* focuses more on the larger evolution of addiction treatment and treatment policy.

Mark Sanders: Are there any cautionary tales embedded in *Slaying the Dragon* for addiction professionals and for the larger field in which they work?

Bill White: There are, and I've expanded the last chapter of the book to offer my own conclusions about such lessons in topical areas like recovery pathways, addiction science, the rise and fall of treatment institutions, the cycles of history within addiction treatment, and the essence of addiction counseling. An example of such a lesson is that harm in the name of help has a long history in addiction treatment and that it is very hard to see such harm within one's own era. We can look back in contempt on the use of cocaine to treat morphine addiction, but one wonders how historians of the future will judge our own era. The study of history can help us avoid or weed out such harmful practices.

Mark Sanders: Where can people get more information on the new edition of *Slaying the Dragon*?

Bill White: The table of contents and a sample chapter from *Slaying the Dragon* are posted on my website at www.williamwhitepapers.com, as is contact information for ordering the book. There are also a large number of my historical papers posted on this site for free download.

Mark Sanders: Bill, thank you for taking this time to discuss your latest book.

Bill White: Thank you for this opportunity. ©

Mark Sanders, LCSW, CADAC, is an international speaker in the behavioral health field whose presentations have reached thousands throughout the United States, Europe, Canada, and the Caribbean Islands. He is coauthor of *Recovery Management and author of Relationship Detox: How to Have Healthy Relationships in Recovery and Slipping through the Cracks: Intervention Strategies for Clients with Multiple Addictions and Disorders*. He is a lecturer at the University of Chicago.



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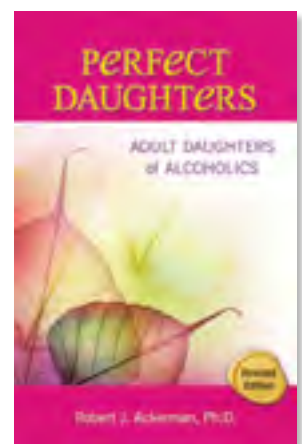
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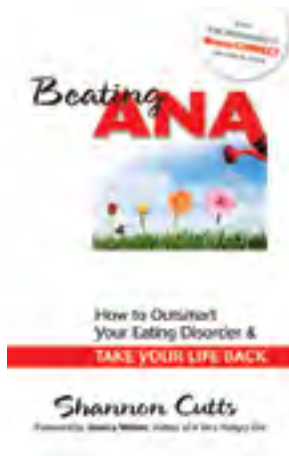
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When this groundbreaking book first appeared over ten years ago, Dr. Ackerman identified behavior patterns shared by daughters of alcoholics—"perfect daughters"—who operate from a base of harsh and limiting views. But more than just a text that identifies behavior patterns, this book collects the thoughts, feelings, and experiences of twelve hundred perfect daughters, offering readers an opportunity to explore their own life's dynamics and to heal and grow.

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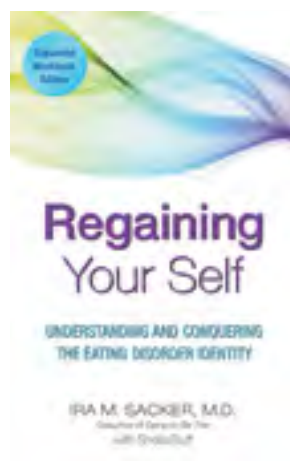
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But this story isn't just about Neen . . . it's about the value of human life, the depth of suffering, and the heights of grace. It is a convincing *cri de coeur* for better practices in the way we treat and counsel those caught in the cycles of trauma, addiction, and serial incarceration. Neen brings us face-to-face with the ubiquitous corruption, neglect, and abuse in some of the systems meant to safeguard at-risk women and children, yet she leaves us with hope that things can change for the better.

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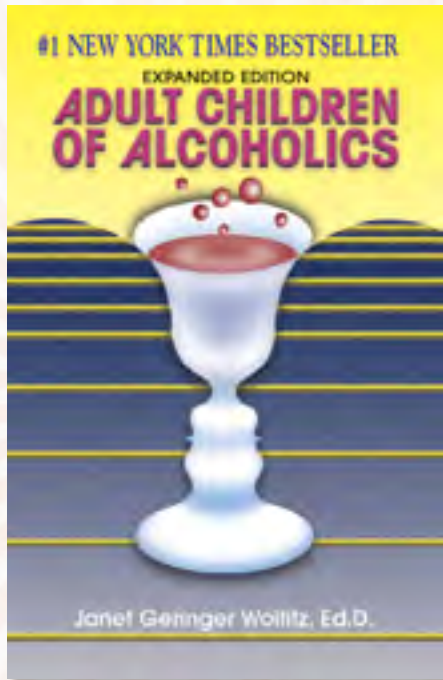
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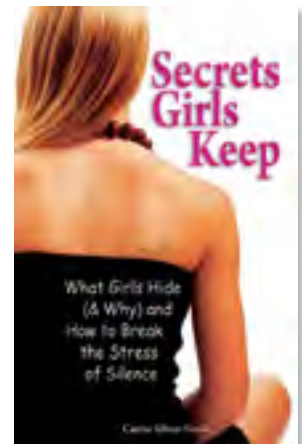
Resources for LIVING

**READ THE BOOK THAT
STARTED AN ENTIRE
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**This book is for every girl with a secret,
which pretty much means every one.**

Girls love secrets, and in many ways, they are trapped by the cult of secrecy that exists today. It is because of this cult that so many girls hide their depression, eating disorders, pregnancies, and sexual relationships. Although secrets can sometimes help us, most often they hurt us, and sometimes even haunt us beyond high school. Here, Carrie Silver-Stock shows how to deal with everyday stresses by being self-reliant (not silent), how to get real about what matters, how to overcome low self-esteem, and shares seven secrets on how to live a better life.



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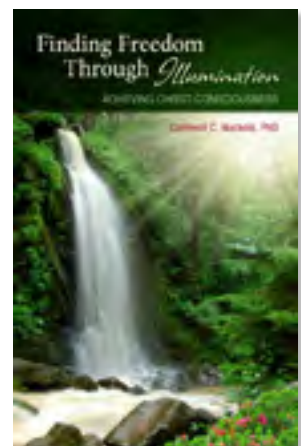
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Adult Children of Alcoholics

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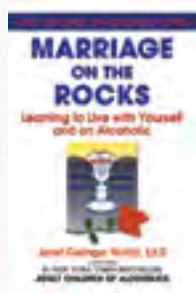
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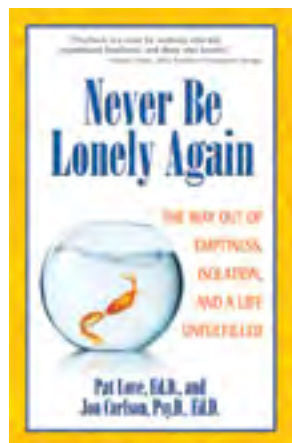


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From the *Journal of
Substance Abuse Treatment*

AFFECT REGULATION

Training for

ALCOHOL USE DISORDERS



Negative affect is viewed as a central mechanism in the development and maintenance of substance use and substance use disorders (Stasiewicz & Maisto, 1993). In addition, negative affect is commonly cited as a reason for alcohol use among alcohol abusers in treatment. Affect regulation, or the ability to regulate affective states, generally refers to the cognitive and behavioral strategies that people use to keep emotions within tolerable levels (Gross, 1998). Individuals who are less skilled at affect regulation may resort to a range of unhealthy behaviors, including excessive alcohol use, in an attempt to regulate negative affect that the individual may perceive as intolerable.

The combination of negative affect and difficulties regulating negative affect has implications for

the development of alcohol problems, as well as recovery. However, few studies have attempted to assess and treat affect regulation difficulties in alcoholic samples (e.g., Berking et al., 2011). An affect regulation perspective proposes adding treatment components to existing alcohol treatment programs to help clients become more comfortable with negative emotional experiences, better able to access and use emotional information in adaptive problem solving, and better able to control emotional experiences and expression of their emotions according to the demands of the situation. Although there is evidence that standard treatments for alcohol use disorders lead to reductions in negative affect (Brown & Schuckit, 1988; Witkiewitz, Bowen, & Donovan, 2011), the addition of an affect regulation intervention to a standard treatment for alcohol use disorders



may lead to greater reductions in negative affect, improved coping skills and affect regulation abilities, and better alcohol treatment outcomes for individuals with an alcohol use disorder. Better outcomes may result both from greater reductions in negative affect and from weakening the connection between negative affect situations and drinking.

Designing the Affect Regulation Training Intervention

Affect regulation training (ART) was developed following a stage model of behavioral therapies research (Rounsaville, Carroll, & Onken 2001), which recommends focusing on treatment development first followed by an evaluation of the treatment's efficacy. The goal of the treatment development phase was the creation of a treatment manual that could be used to supplement standard cognitive behavioral therapy (CBT) for alcohol use disorders. More specifically, the ART treatment manual was developed to address the needs of alcohol dependent men and women who reported frequent heavy drinking in negative emotional situations—in other words, negative affect drinkers. Based upon the literature linking negative affect and drinking, including the association between deficits in affect regulation and problematic alcohol use, ART was designed to include cognitive and behavioral strategies addressing a prolonged direct experiencing of emotion utilizing guided imagery techniques, mindfulness skills, and several coping and distress tolerance skills. These affect-regulation strategies were derived from interventions that address a range of mental health

disorders—panic, posttraumatic stress disorder (PTSD), depression, and borderline personality disorder, to name a few—as well as substance use disorders, and differ from traditional cognitive-behavioral-skills-based interventions by placing greater emphasis on increasing the client's ability to experience and regulate the subjective, physiological, and behavioral components of negative emotion and less emphasis on teaching the client how to “change” the emotion or the situational and cognitive elements that precede the emotion. Specifically, mindfulness and prolonged direct experiencing instruct the client to focus on the emotion itself, and to let thoughts, feelings, and sensations come and go, rise and fall away, without attempting to exert control (Breslin, Zack, & McMair, 2002). These two therapeutic techniques are known to often deepen a client's awareness of the physical sensations, thoughts, emotions, and urges that often precede substance use. Learning to “stay with” or tolerate these experiences can bring about important changes for the client such as reduced reactivity to internal and external substance use cues and increased self-efficacy for tolerating unpleasant sensations, thoughts, and emotions.

The goal of the treatment evaluation phase was to compare the clinical efficacy of twelve sessions of CBT for alcohol dependence plus an affect regulation training supplement (CBT + ART; $n = 39$) to CBT plus a health and lifestyles supplement (CBT + HLS; $n = 38$). ART was developed as a supplement to standard treatment for alcohol dependence because it places greater emphasis on managing negative emotion drinking situations and relatively

less emphasis on specific strategies for changing drinking behavior. Both treatments were manual guided and consisted of weekly, ninety-minute treatment sessions for twelve weeks (see Table 1 on page 70 for a list of ART and HLS treatment sessions). During each weekly session, the first forty-five minutes were devoted to CBT and the remaining forty-five minutes were devoted to ART or to HLS. The study was conducted to determine if individuals randomized to receive CBT + ART would show greater improvement on drinking outcomes, show greater reductions in negative affect, and show greater improvements in affect regulation skills when compared to individuals randomized to receive CBT + HLS. All clients were seeking outpatient treatment services, received a current DSM-IV diagnosis of alcohol dependence, and reported frequent heavy drinking in negative emotional situations.

All clients, regardless of whether they received ART or HLS, received twelve weekly sessions of CBT for alcohol dependence (Kadden et al., 1992). Each session contained information such as identifying and coping with drinking triggers, building sober supports, discussion of AA, and other topics typically found in standard alcohol treatment. In addition, the CBT session content minimized discussion of affect-related topics and did not overlap with the ART or HLS treatment content.

Description of the ART and HLS Interventions

The ART treatment is comprised of several affect regulation strategies adapted from existing therapies that have specific procedures for helping patients develop the capacity to regulate negative affect in healthy ways. Therapies consulted in the development of ART included dialectical behavior therapy (Linehan, 1993), mindfulness-based cognitive therapy for depression (Segal, Williams, & Teasdale, 2001), and prolonged exposure therapy for PTSD (Foa, Hembree, & Rothbaum, 2007). Specific strategies adapted for use in ART included behavioral analysis of inter- and intrapersonal drinking situations involving negative affect (Sobell, Toneatto, & Sobell, 1994), several distress tolerance skills (Linehan, 1993), mindfulness-based cognitive strategies (Marlatt, 2002; Segal et al., 2001), and prolonged direct experiencing of emotion which uses guided imagery to facilitate engagement with the unpleasant emotion, as opposed to escape or avoidance. The HLS treatment was intended to serve as an active control and provided education about a variety of health-related topics (see Table 1). Treatment sessions included information and discussion with the clients.

The Essence of ART: Direct Experiencing of Negative Emotion

Negative affect plays a prominent role in a range of mental health disorders, including substance use disorders, and successful treatment of these disorders must include procedures for the clinical management of negative affect. One strategy, common to many interventions, is the direct experiencing of negative emotion. Whether through imagery, mindfulness, role play or discussion of high risk situations, direct experiencing of negative emotion is viewed as an important step in the change process. The direct experiencing of negative emotion is conceptually similar to behavioral exposure and response prevention and is thought to increase a person's ability to tolerate or accept unpleasant emotions; reduce learned and maladaptive emotional and behavioral responses to negative emotion, such as reducing substance use in response to negative emotions; and increase self-efficacy for managing future negative emotions.

ART facilitated the prolonged direct experiencing of emotion using guided imagery of individualized negative affect drinking situations and mindfulness to help manage urges, cravings, and negative emotions. The negative emotional drinking scenes were developed using a guided imagery worksheet developed for this study. The worksheet included questions about the client's thoughts, feelings, physical sensations, and other internal and external cues present during the negative emotional drinking situation. Prior to each imaginal scene presentation, the counselor instructed the client to "really feel the emotions, to accept them and remain in contact with them, without trying to suppress them or push them away." These instructions were



provided to make the experience as much like “real life” as possible so as to maximize the potential therapeutic benefits of the technique.

At their intersection, both mindfulness and prolonged direct experiencing of emotion involve paying attention in the moment, observing one’s thoughts, feelings, and physical sensations without judging them or trying to suppress, avoid or escape them. The primary focus of both techniques is on the client’s direct experience in the moment. Similarly, various components of these strategies are incorporated into the “urge surfing” technique (Marlatt, 1985). Urge surfing encourages the client to imagine an urge or a craving as an ocean wave, and to observe the urge as it rises up, crests, and then subsides before gently washing up on shore. With all of these strategies, the therapist provides encouragement and assistance in redirecting the client back to the present moment and emphasizes the importance of being accepting of the experience. A key element of ART, or any intervention that addresses disorders of affect regulation, we believe, is one of engagement with—rather than suppression or escape from—one’s urges, cravings, and emotional experiences (see the “Suppression vs. Engagement” text box). Therefore, in ART, we employed prolonged direct

experiencing of emotion and mindfulness to help the client learn that emotions and urges will pass and that they can manage these experiences without the need to drink.

When using the techniques of mindfulness and prolonged direct experiencing of emotion, the therapist is creating a safe therapeutic space in which the client can engage with negative emotions without responding or reacting in the usual ways. While practicing staying with intense or uncomfortable emotions, rather than attempting to avoid or escape them, the client learns about the time course of an emotional response, how it unfolds, and the unique sensations, thoughts, and secondary emotions that may arise and which may precede the use of substances. Clients may learn that the unpleasant emotional response begins to decrease within a few minutes, or that the urge or craving for alcohol follows the same wave pattern as the emotional response. Finally, the client may learn that a different outcome is possible, that they can accept and tolerate the uncomfortable experience of an urge or negative emotion without engaging in substance use to avoid or escape. Repeated exposures will help strengthen this new learning and the client can be encouraged to use these skills when experiencing negative emotions in everyday situations.

SUPPRESSION VS. ENGAGEMENT

Talking about urges might be considered off-limits by some therapists and admitting urges might be denied by some clients. To discuss urges, or to admit to them, may be viewed as a threat to the client’s treatment for two separate yet related concerns. First, a therapist may feel that discussing or otherwise drawing attention to urges may trigger a relapse. Second, a client may feel that to acknowledge an urge is to admit that treatment is not working. However, individuals who attempt to suppress urges and negative emotions are more likely to experience “rebound” effects (Sayers & Sayette, 2013). For example, attempts to suppress an urge may produce stronger and more frequent urges. Therefore, it’s been suggested that an urge or negative emotion be viewed as a signal alerting the person that something is wrong and requires attention (Bien & Bien, 2002). Both mindfulness and prolonged exposure promote turning one’s attention toward the unpleasant or unwanted experience rather than away from it. When used skillfully, these techniques allow the client to see that the unpleasant experience will pass. Often, the client gains a deeper understanding of what triggers these experiences and learns to “stay with” or accept the unpleasantness rather than feeling a reactive need to suppress or avoid it.

Results

Excellent levels of client acceptance and satisfaction with ART were accompanied by promising results in support of the treatment approach. The findings indicate that supplementing standard CBT for alcohol dependence with ART significantly reduced drinking for alcohol dependent clients who reported frequent heavy drinking in negative emotional situations. For percent of days abstinent, drinks per drinking day, and percent heavy drinking days, those receiving ART had greater gains on these outcomes from pre- to posttreatment when compared to those receiving HLS. In addition, for percent of days abstinent and percent heavy drinking days, the gains were maintained at three- and six-month follow-up. Changes in several characteristics of mindfulness and in negative affect also support further investigation of ART’s usefulness as a treatment supplement delivered concurrently with CBT for alcohol dependence. Specifically, those who received CBT + ART reported reductions in negative affect and increases in two facets of mindfulness, observing, and describing. We think that the combination of mindfulness and prolonged direct experiencing of emotion helped facilitate these changes by allowing clients an opportunity to experience the activation and reduction of negative emotions without attempting



to avoid or escape them. Engaging with their negative emotions allows clients the opportunity to learn that their emotions will change over time and, importantly, that they do not have to react (i.e., drink or use drugs) in the moment to escape or avoid the emotions. Such corrective learning is an integral part of mindfulness-based therapies and several theoretical models that offer an explanation for how behavioral exposure and response prevention therapy works (Foa & Kozak, 1986).

TABLE 1. SUMMARY OF TREATMENT CONTENT FOR ART AND HLS

	Affect Regulation Training (ART)	Health and Lifestyle (HLS)
Session 1	Introduction to Treatment	Introduction to Treatment
Session 2	Negative Affect Monitoring	Negative Health Consequences of Heavy Alcohol Use
Session 3	Mindfulness Training to Improve Emotion Identification	Drinking and Driving
Session 4	Integrating Mindfulness and Experiencing Emotions	Personal Values and Priorities
Session 5	Cognitive and Behavioral Coping Skills for Managing Negative Affect	Monitoring Session
Session 6	Coping with Overwhelming Emotions	Role Identification
Session 7	Prolonged, Direct Experiencing of Negative Emotions: I	Reducing HIV Risk or Protecting your Health with HIV
Session 8	Prolonged, Direct Experiencing of Negative Emotions: II	Healthy Eating and Nutrition
Session 9	Prolonged, Direct Experiencing of Negative Emotions: III	Monitoring Session
Session 10	Prolonged, Direct Experiencing of Negative Emotions: IV	Starting/Maintaining an Exercise Program
Session 11	Enhancement of Positive Emotions	Screening for Breast Cancer (Women) or Colorectal Cancer (Men)
Session 12	Review and Termination	Review and Termination

Conclusions and Future Directions

We developed and tested a novel treatment supplement for alcohol dependence designed to address the problem of negative affect drinking. Following the stage model of behavioral therapies research, we were able to demonstrate excellent patient acceptance of ART, the feasibility of conducting ART in an outpatient setting, and clinically significant patient improvement. While these results are encouraging, future work in this area should focus on helping clients learn skills for actively modifying negative emotions. For example, while individuals who received CBT + ART demonstrated decreased negative affect and improvements in two mindfulness skills, observing and describing, there were fewer changes in affect regulation skills designed to actively modify negative emotions. Such skills could include active problem solving, seeking guidance, and curbing impulse control problems, among several others. In a previous study involving inpatients being treated for a variety of mental health disorders, improvements in patients' abilities to actively modify, accept, and tolerate negative emotions were the strongest predictors of treatment gains (Berking, Ebert, Cuijpers, & Hofmann, 2013).

With its inclusion of mindfulness and prolonged direct experiencing of negative emotion, ART places greater emphasis on awareness, tolerance, and acceptance of negative emotions than it does on promoting the acquisition of skills for actively modifying negative emotions. One affect regulation skill that shows promise across a range of problem behaviors is cognitive reappraisal, which involves changing how one thinks in order to influence one's emotional response (DeSteno, Gross, & Kubzansky, 2013). Although ART did not include a cognitive reappraisal skill-building session, individuals who received ART reported more improvement on a measure of reappraisal compared to those who received HLS. However, the observed change in reappraisal was a small effect and may have occurred *after* engaging in mindfulness and prolonged imaginal exposure to negative affective drinking situations. In other words, by emotionally processing high-risk negative affect drinking situations individuals learned that they could tolerate the unpleasant emotions without resorting to substance use. Alternatively, individuals can be actively instructed to use reappraisal *before* encountering a high-risk negative emotional situation or in the early stages of a negative emotion-eliciting situation with the goal of altering and/or reducing the emotional impact of the event. In this way, the client, like a surfer, learns to recognize the ocean swell before



it becomes a wave. With regard to future directions for ART, it will be interesting to see if treatment outcomes can be enhanced by the addition of skills designed to actively modify negative emotions. **C**

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THE PAUPER AT HIS PALACE:

An Integrated
Model for
Treatment of
Dual-Diagnosis
Adolescents in the
Residential Setting

The challenge

of integrating treatment is not new to the medical world. Any patient struggling with a chronic illness is frequently seen by a team of treatment professionals who attempt to collaboratively address the unique needs of the patient.

Addiction treatment in particular, however, has historically developed along polarized lines, often leading to clashing models of medical, social or psychological paradigms. The investment in a single model creates a treatment silo. These models, or silos, can fail to integrate, often viewing each other as having an incomplete or incorrect understanding of the same disease they are trying to treat (Havassy, Alvidrez, & Mericle, 2009). In the following discussion we use case material to illustrate our effort to construct an integrated treatment approach in the adolescent residential chemical dependency treatment setting. You will experience the perspectives of Dr. David E. Smith, “The Maverick” who pioneered medical treatment of addiction in the early 1960s through the creation of the Haight-Ashbury Free Clinic; Dr. Michael Wachter, “The Paradoxical Psychiatrist” who spends more time listening than prescribing; and Jennifer Golick, LMFT, the “Intrepid Therapist” who immerses herself into the family system. The model used to exemplify integration is formally identified as case formulation. We will explore this model of integration through the lens of a sixteen-year-old patient and his family.

The Maverick

Substance abuse in all its forms represents our country’s number one

adolescent public health problem (CASAColumbia, 2011). Peak incidence for the onset of substance use disorder (SUD) is between ages fifteen and twenty-one, with the leading cause of death in this age group being drug overdose followed by fatal auto accidents, many of which are related to drunk and/or drugged driving.

This surge in drug overdoses has been fueled in large part by the increase in prescription drug abuse in the adolescent and young adult age group, coupled with the recent heroin epidemic in suburbia and rural areas of the US, challenging the traditional view that addiction is essentially an urban, inner-city problem (CASAColumbia, 2011). Studies have found that 20 percent of SUDs have a co-occurring Axis I psychiatric disorder. Furthermore, there is growing awareness of reward deficiency syndrome (RDS) and comorbid process or behavioral addictions (Smith, 2012).

Propelled by the National Institute of Drug Abuse (NIDA), the 1990s were declared “The Decade of the Brain.” This allowed scientific pressure to be exerted upon the treatment communities to develop integrated treatment models because there are “no silos in the brain.” New treatments offered an integrated biosocial/psychological/spiritual/holistic approach, dealing with all aspects of an individual’s neurobiology and life function. This trend in treatment focused on evidence-based and patient-centered treatment, often in conflict with rigid, modality-driven programs. Such integrated treatment is particularly important for adolescent early-onset addiction with clinically significant comorbid psychiatric disorder.

The partitioned approach is particularly counter-productive with dual-diagnosis patients. Dual-diagnosis disorders are defined as the coexistence of a substance use disorder (SUD) and a comorbid mental illness. According to the 1999 Surgeon General’s Report, about one-third of adults with a SUD have another psychiatric disorder, while 15 percent of adults with a psychiatric disorder meet the criteria for a SUD (ASAM, 2000).

The therapeutic approach to patients with a mental illness and a co-occurring

SUD is complex, because different therapies are appropriate for different addiction and mental disorders. Dual-diagnosis patients may need medications for their psychiatric disorders, and entirely different classes of medications for their substance dependence, such as buprenorphine (Grau-López et al., 2014). Specific research has established that medication-assisted treatment (MAT) of opiate addiction increases patient retention and decreases drug use, infectious disease transmission, and criminal activity (NIDA, 2012). MAT of opiate use disorder is supported by the Substance Abuse and Mental Health Services Administration (SAMHSA), the National Institute of Medicine (NIM), and the World Health Organization (WHO).

The goal is holistic recovery that allows individuals to live productive, fulfilled lives as they effectively manage the symptoms of their disorder. Over the past forty years of my experience in addiction medicine I have observed the power of each silo grow and expand. Our current challenge is to integrate the silos into a synergistic and unified approach to treating the addicted population, now formally recognized by The American Society of Addiction Medicine (Cavacuiti, 2011). I continue to work toward an integrated, multidisciplinary approach to addiction treatment and, thankfully, I am no longer considered an outlier.

The Paradoxical Psychiatrist

As the consulting psychiatrist at Muir Wood Adolescent and Family Services, I will continue Dr. Smith’s discussion from the perspective of his mandate for integrated treatment. Our program relies on the Twelve Step social model with our recovery counselors and milieu, a medical model to manage detoxification and other medical comorbidities, a psychiatric model to evaluate psychiatric comorbidities, and a psychological model to effect behavioral change for the adolescents and their families through intensive individual and group therapy. Hence, without a unifying construct we run the risk of “siloed” thought and treatment philosophy regarding clients and their families.

The model that we use to integrate the Twelve Step, medical, psychiatric, and psychological paradigms is the well-delineated case formulation. This model is concisely outlined in psychiatric literature, with a practical discussion of “its structure, purpose, and application” (Perry, Cooper, & Michels, 1987; Winters, Hanson, & Stoyanova, 2007; McWilliams, 2013). We, along with numerous other authors, believe that the collective group construction of the case formulation model creates inclusion through a shared stance of curiosity.

We will use case material of a sixteen-year-old, dual-diagnosed adolescent and his family to take the reader through the construction of a case formulation. The case formulation is constructed collaboratively with our multidisciplinary team of recovery counselors, physician, psychiatrist, therapist, and clinical director. The forums for contribution include multidisciplinary treatment planning, daily shift reports, individual assessments, and all available relational experiences between program and client/family. To illustrate, a report of staff interaction in a car ride to the gym or an outside meeting may provide data as important as that obtained from the seemingly more formal admitting psychiatric evaluation. This data can fundamentally change or expand the initial formulation.

We also subscribe to the “relational” view of the treatment experience in the construction of the formulation. This is a contemporary school of psychological thought, with compelling discussion of its value in engaging, retaining, and developing strong therapeutic alliance in adolescent chemical dependency treatment (Mitchell, 1995; Director, 2000, 2002, 2005). The fundamental aspect of the relational model is its focus on the two-person field, thus examining the evolving therapeutic relationship between client and clinician, rather than merely observing the client and family as singular entities. The clinician and the patient are in treatment together.

Case formulation has three main components (see also Smith,

Wachter, Golick, & Sowle, 2014). The first component includes external stressors. For this client they include homelessness, substance use, substance induced psychosis, learning disorder, academic failure, unstable and dangerous peer relationships, ruptured family dynamics, and recent treatment failures, just to name the most overt. Of note, many of these external stressors are individual diagnoses unto themselves, certainly qualifying this patient for dual-diagnosis status.

Frequently treatment stalls at this juncture, burdened by the high density of external stressors, diagnoses, and a reflex to respond to them algorithmically.



Hence, the first part of the formulation is a list of external problems, most of which carry a valid demand for external treatment interventions.

The second part of the formulation is designed to understand the unique psychological makeup of the client and family, which we will be discussing in great detail. It is a comprehensive description of the client’s personality structure, including wishes, fears, and defenses. We believe that the standard treatment interventions cannot be taken

up equally or generically by any two clients, and must be adjusted to consider the psychological structure.

Data for the second part of the formulation is collected by the interpersonal or relational experience between client and clinician. Careful attention is directed toward understanding the subjective experience in the room between client and clinician, even while gathering the “factual” past history and present history outside the room. Close attention is paid to the style or process of the interview, which can be distinct from the content. How a client tells his story is as important as the content of the story. Does the client

seem credible? What is his affect? What are his defense mechanisms?

Data to answer these questions comes from the internal experience of the clinician conducting the interview. What feelings emerge while listening to the story? How do those feelings affect our line of questioning and thinking? These are long held fundamentals in psychotherapy, collectively referred to as “countertransference.”

The third part of the formulation is to make an early prediction of the

client's response to the total treatment situation based on the interaction of the client's personality with the staff and program. The goal of this prediction is to orient us to the client at the greatest available depth of relationship, thereby establishing early engagement and therapeutic alliance.

We will focus the reader on the second and third components, perhaps most usefully considered together as the psychological and relational parts of the formulation. This is distinct from, yet used in conjunction with, the external data described below.

Our client is a sixteen-year-old boy admitted for severe substance use disorder including amphetamine-induced psychosis. External stressors are extensive; however, the chief stressor we will explore from a relational perspective is his homelessness. He lives on the street, immediately outside his parents' comfortable residence, with the assertion that he is a functional adult. He periodically comes home, but the family's concern at the time of admission is that he is "emancipated," thereby limiting their ability to admit him involuntarily to treatment. He is, therefore, at the time of admission, a pauper outside his palace.

In my psychiatric assessment I make note of the subjective quality of the interview:

This is a very engaged adolescent male, who presents himself as extremely mature, autonomous, separated from his parents, and able to live successfully as an adult on the street. His interview style is very controlling in the way he dictates the rate, pace, and contents of the interview. He does not want to be interrupted and has a very organized and methodical way of presenting his story. This does appear somewhat defensive as he is distressed and disorganized by questions that might disrupt the flow of his rigid narrative. This lends a pseudomature quality to his presentation, where he wants to appear "adult," but demonstrates fear and limitation in an adult interpersonal exchange.

Based on my relational experience of the interview, an early, speculative model of the client's character structure can be formed. I draw on here-and-now dynamics of the interview to extrapolate into past and present relationship style. A general sense of uniqueness begins to form, as no two clients have the same permutations of events, experiences, and relational style. My early prediction in this case is as follows:

In predicting a response to therapeutic situations, we should consider this patient's pseudomature development, wherein he imagines he can reject his parents and his illness, and live as an autonomous adult. This pseudomaturity appears as a centrally organizing defensive stance. He works hard, however, to preserve this stance in the interpersonal context of the interview, lending it a rigid and brittle quality.

He simultaneously appears relieved to be in treatment and potentially curious about his experience with us and his family. This speaks to underlying wishes for containment and dependency, palpable beneath his thin pseudomature veneer. This poses a conflict about autonomy and dependency, which will likely manifest behaviorally with staff and peers. We can anticipate a broad spectrum of distress as we necessarily make "contact with the conflict" (Vedder, Ament, Gossard, & McCready, 1993; Bromberg, 1991).

Our clinical director, Jennifer Golick LMFT, next takes us through the relational experience of the case. She speaks from her personal subjectivity, informed by her immersive interaction with the recovery counselor staff; client, family, medical and psychiatric team; and staff therapist, as well as her own individual and group therapy work.

The Intrepid Therapist

I have observed that maturation, in all its aspects, holds tremendous importance in the mind of the adolescent and his or her parents. What is the rate of maturation? Will the teen reach a point of maturity in relationships, work, self-determination, and autonomy to be

successful in the world at age eighteen? Can he or she go to college, obtain a job, and begin to live independently with the rest of "adult society"? Here we present a case with a central formulation theme of the maturity, or in this case, the pseudomaturity (Bromberg, 1995; Goldberg, 1995; Meltzer, 2008; Mondrzak, 2012) of an adolescent client and his family.

This case began with several phone calls from the parents during the initial preadmission screening. The parents, let's call them Shelly and David, sought treatment for their endangered sixteen-year-old son, who we will call Roger, but expressed helplessness in dealing with their perception of his "emancipation to adulthood" at age sixteen. They described a boy living on the streets outside their residence, truant from school, nearing psychosis with stimulant use, embraced by a homeless peer group, and defying them to intervene, as he was "an adult." Roger was not running away, made periodic visits home, and had essentially declared himself a poor adult living just outside his home, as a pauper outside his palace. The problems of dealing with their poorly developed, but "adult" or pseudomature son paralyzed Shelly and David. Their confusion about his maturity then led to confusion about the right context for treatment.

They decided to admit Roger to our program, using adult negotiation to "collaboratively" engage him in the process. David purchased cigarettes for Roger during his transportation, in deference to his "adult" status, and to "collaborate" on the admission. At one point while they were en route to treatment, Roger initiated a phone call with the executive director to advocate for his ability to smoke in treatment. This was a foreshadowing of things to come, demonstrating Roger's desire to dictate terms of an adult treatment.

Roger spent the majority of the first weeks talking about prior treatment episodes, comparing and contrasting treatment programs by endorsing what he described as his previously superior treatments, emphasizing his "adult" experience of a brief stay in a sober living

environment. He also spoke at length of his “street wife” and “street family,” all of whom were actual adults who had chosen the lifestyle of homelessness and lived in an encampment near Roger’s family’s residence. He frequently referenced these individuals as his chosen family and made regular declarations about his desire to return to them as a relational family of origin rather than his own biological family.

When I began interacting with Roger, I was struck by his need to present himself as a mature adult to staff and other residents. This presentation had an awkward and fragile quality. I sensed it was a “pseudomaturity” that was not rooted intrapsychically. My own countertransference began to arise around his resistance or inability to integrate information, stating he had “heard all of this” during his previous treatment episodes. This knowledge of Twelve Step recovery and psychological underpinnings, however, did not translate into behavioral or cognitive changes and remained isolated in an intellectual silo.

The staff that interacted with him daily had their own set of reactions to Roger’s pseudomaturity, primarily defaulting to treating him like an adult client and focusing on self-actualization in the service of independence. They encouraged him to make decisions about his discharge plan that were in direct conflict with his age and ability to execute. Shelly and David initially met this approach with gratitude, expressing their appreciation of staff’s ability to support their son.

They began to develop resistance to this stance of the recovery staff, however, as they evolved their own leanings toward discharge preferences. I could see their difficulty in expressing their leanings directly, preferring instead to wish that Roger would choose their private plan as an independent adult.

I felt their ambivalence to directly express their parental needs and desires to their son. Shelly and David frequently deferred difficult conversations to me, placing me in the position of messenger. In spite of my encouragement for them to find their own voices in treatment,



they seemed paralyzed by their fear that if they took a stance with their son they would invoke his rage and precipitate his rejection of treatment.

The family therapy was hence initially very tenuous, and Shelly and David seemed reluctant to allow us in to the issues in their family system. They seemed afraid of expressing themselves to their “adult” son. Most of the conversation was kept at the surface level, ostensibly to keep Roger from reacting in anger. They frequently deferred to Roger in therapy, allowing him to dictate the subject matter and to decide when a particular subject was off-limits.

Over time, it became evident that their inability to speak directly was causing Roger significant agitation. He repeatedly asked them for direct answers to specific questions, such as duration of treatment, discharge plan, a potential family move, etc. Their difficulty answering helped us see a fundamental conflict in their interaction with their pseudomature son; they wanted to address his density of problems with learning, academic

status, peer relationships, and life threatening substance use, but at the same time wished him to be an adult, past all these problems and ready to function autonomously in the world. Pseudomaturity *seemed* to work for everyone and cracking the shell was met with resistance—outrage by Roger and paralysis by his parents.

I noticed that Shelly and David took copious notes during the family therapy sessions, psychoeducational courses, and multifamily process groups. At one point Roger questioned the reasoning behind the note taking and asked me, “Do you think they even read what they wrote?” As my treatment relationship with the family deepened, it was revealed that David, who was an Ivy League graduate, suffered from the same auditory processing disorder as Roger. David compensated for this through his use of note taking, which may have served more to manage anxiety than to create references. Shelly also had significant cognitive distortions, particularly around the anger that she perceived Roger to be incubating. She had difficulty seeing that Roger was fundamentally angry at

DUAL-DIAGNOSIS ADOLESCENTS

his parents' inability to make decisions or have definitive dialogue, which risked cracking the pseudomature shell.

My family therapy work with Shelly and David became increasingly frustrating on a countertransference level, due in large response to their inability to make a decision about discharge planning. They were unwilling to commit to aftercare decisions because they perceived that Roger had to choose his own plan to comply. I began to see how Roger's pseudomaturity became solidified in direct response to Shelly and David's own need for maintaining it.

From a treatment perspective, this relational dynamic helped enhance the formulation and the treatment interventions that followed. Shelly and David, in their inability to assert their role as parents and leaders in the family, frequently deferred to Roger's desires regarding discharge planning and treatment. Roger became increasingly agitated toward his parents as his questioning of transition plans and future goals was met with equivocal responses. We consolidated our formulation in treatment planning, now organizing our team around the problem of pseudomaturity within the family system.

This helped prepare me for interactions in the moment with Roger and his family. In one particularly poignant

session, Roger asked, "Am I going to have to stay in treatment longer and do I have a choice in the matter?" I responded spontaneously, in an uncharacteristically direct and authoritative manner, by saying "Yes, you're staying longer; no, you don't have a say in the matter." He became visibly relieved and relaxed immediately, responding simply, "Thank you."

It appeared that a direct answer to a direct question was comforting, as it had not been his experience within his own family system. In essence, Roger asked to be parented by me. By my responding to him in an age-appropriate manner, rather than engaging or reinforcing his pseudomaturity, he was able to experience the relief that came from the containment by the direct response.

I experienced this moment as a pivotal turning point, as I was able to observe the shift in Roger from agitated "adult" client in need of dictated treatment to an adolescent boy relieved to know what the next steps would be. I brought this personal experience to the treatment team as data to incorporate into the case formulation. We collectively paused and recalibrated our understanding of each of our points of contact with Roger and his family.

Paradoxically, as Roger began to demonstrate increased maturity and personal agency through his recovery,

Shelly and David appeared to unravel and become less mature. David showed increasing outbursts of anger and frustration, particularly in his email exchanges with me. He began to use profanity in a way that was incongruous with his normal presentation. He also had a flare up of rosacea, which seemed coincidental with his increasing internal frustration and distress.

David increasingly demonstrated resentment toward Roger, feeling that his addiction and associated behavior had dominated the entire family. This contrasted with the initial presentation, where the family had been willing to make whatever accommodations necessary to support Roger's recovery. Shelly and David also became increasingly resentful that Roger, when given several choices for discharge locations, would not choose the facility that they preferred. This was confusing and frustrating for Roger, as he had difficulty navigating his own desires, much less the unconscious desires of his parents.

I brought my relational experiences to the treatment team, who could use them as data, even if it was encoded in the private language of Twelve Step, psychiatry or psychology. This lent organization and cohesion to our collective formulation. We could then organize a discharge plan to a long-term structured treatment setting, where Roger could remain sober and begin to address the multiple deficits in his development.

Once the discharge plan was established, and a therapeutic boarding school was chosen, there was a marked shift in Roger. He became more comfortable with being age appropriate, and hence seemed more mature and grounded in himself. He was able to speak calmly and intelligently, and advocated for his needs in a way that he had not been able to previously.

Conversely, Shelly and David became increasingly fragile as discharge loomed. They made an unconscious attempt to undo Roger's progress by suggesting a week-long vacation in California as a transition between programs. It was striking to feel their discomfort with





Roger in his newfound actual maturity versus his previous pseudomaturity.

We could now understand how the pseudomature construct was failing everyone. The parents were unable to address their real child and Roger was unable to experience the safety of childhood containment from his parents. This fundamental understanding became the core of our multidisciplinary treatment team formulation, enabling us to incorporate Twelve Step, medical (psychiatric), and psychological perspectives in our work with Roger and his parents.

The success of the case was not only in helping Roger mature; it was also in achieving an organized plan that the presenting construct of pseudomaturity precluded. Roger accepted a developmentally appropriate discharge placement and his parents took more responsibility for administering it.

The treatment team continues to discuss our experience of Roger and his family. Perhaps each subgroup uses private internal language; however, we can all refer to our collectively evolved formulation of pseudomaturity as we get updates from his current treatment setting, and apply this to our formulation. This permits us to add to or revise our ongoing understanding of his maturation and his overall progress through recovery. We can then question

our past interventions and modify our future predictions.

This case exemplifies our use of case formulation to integrate the Twelve Step, psychiatric, and psychological components of our own multidisciplinary treatment team. Specific aspects of this case have relevance to other cases, which aids subsequent formulations. But more importantly, the process of building a case formulation as a team carries our commitment to integration into our approach to subsequent cases. We see a meta-effect of each case formulation enhancing subsequent formulations by virtue of both content and process. We seek to keep our experience of treatment, not just the information gleaned from it, out of the rigidity of silos, and integrated into a more cohesive clinical application. **C**

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Process Addictions: An Overview

1. Which of the following was listed as a factor that could contribute to the development of a process addiction?

- Ⓐ Age
- Ⓑ Poverty
- Ⓒ Gender
- Ⓓ All of the above

2. According to the authors, which of the following process addictions is the most understood?

- Ⓐ Eating disorders
- Ⓑ Internet addiction
- Ⓒ Gambling disorder
- Ⓓ Sex addiction

3. True or False. Parkinson's disease provides a good lens through which some process addictions can be studied.

- Ⓐ True
- Ⓑ False

4. Naltrexone is a successful treatment for all of the following disorders, except:

- Ⓐ Kleptomania
- Ⓑ Hypersexuality
- Ⓒ Compulsive shopping
- Ⓓ Trichotillomania

5. True or False. Young males are less likely to develop disordered gambling problems than young females.

- Ⓐ True
- Ⓑ False

What's New in Problem Gambling?

1. According to the author, what constitutes convergent content?

- Ⓐ Online penny auctions with gambling elements
- Ⓑ Video games with gambling elements
- Ⓒ Both A and B
- Ⓓ None of the above

2. True or False. *Bingo Friendzy* was depicted on Facebook's October 2013 monthly figures as one of the most popular games played, with twenty-four million players around the world.

- Ⓐ True
- Ⓑ False

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3. Which of the following was not listed as a definition of a “screenager” or “digital native”?

- (A) They have never known a world without the internet
- (B) They have no technophobia
- (C) They know not to trust some new technologies
- (D) They are tech-savvy

4. True or False. In-play sports betting involves the ability to bet multiple times during a single televised sporting event.

- (A) True
- (B) False

5. Which of the following was not listed by the author as a reason people are likely to seek online help for problem gambling?

- (A) Accessibility
- (B) Convenience
- (C) Anonymity
- (D) None of the above, these are all valid reasons

The Food Issues Eating Us Alive

1. Which of the following was not listed as a cause of food addiction?

- (A) Lack of willpower
- (B) Faulty brain wiring
- (C) Chemical properties of certain foods
- (D) Both B and C

2. According to the author, which of the following is not something that happens when trigger foods are removed from food addicts?

- (A) Anxiousness and fear increase
- (B) Withdrawal symptoms appear
- (C) Feel-good chemicals in the brain increase
- (D) Sleep is disturbed

3. True or False. One in three adults and one in five children are considered obese.

- (A) True
- (B) False

4. A diet for treating the body of a food addict should adhere to all of the following criteria, except:

- (A) Includes all the main food groups
- (B) Satisfy hunger
- (C) Have boundaries with food
- (D) None of the above, these are all valid criteria

5. True or False. According to Newberg and Waldman, spiritual practices reduce stress and contemplating God decreases anxiety.

- (A) True
- (B) False

Counselor Magazine Evaluation Quiz

Scale: 1 (low) – 5 (high)

Presenter (USJT)

Knowledgeable in content area

1 2 3 4 5

Content consistent with objectives

1 2 3 4 5

Content

Information was suitable and useful to course topic

1 2 3 4 5

Article was appropriate to my education and licensure level

1 2 3 4 5

Information in the article was current

1 2 3 4 5

Appropriate for intended audience (Intermediate to advanced levels)

1 2 3 4 5

Clarity of content

1 2 3 4 5

Support

Did you need to contact the Program Administrator?

1 2 3 4 5

LEARNING OBJECTIVES:

After reading the following articles, the participant should be able to:

Process Addictions: An Overview

1. Explain that process addictions, like substance use disorders, make use of the mesolimbic and mesocortical neural pathways.
2. List the medications that have been successful in treating process addictions, such as naltrexone, paroxetine, citalopram, and escitalopram.
3. Discuss the risk factors for developing a process addiction problem, which may include trauma, preexisting psychiatric issues, poor impulse control, and an existing substance abuse problem.
4. Compile a list of medications that assist particularly with gambling disorders, such as fluvoxamine, carbamazepine, amantadine, and lithium.

What's New in Problem Gambling?

1. Demonstrate how the use of technology by young people is increasingly becoming an issue as these “screenagers” and “digital natives” might first experience gambling in online milieus, rather than offline.
2. List the new trends in gambling, such as in-play sports betting, gambling via social networking sites, mobile gambling, and gambling via interactive television.
3. Explain how behavioral tracking data has been shown to detect patterns in problem gamblers online, which can lead to further research and identifying problem gambling before severe consequences arise.
4. Analyze how online help is an up-and-coming method of treatment for problem gamblers who may have barriers or be unwilling to seek other forms of treatment, as it can help them overcome social stigma and other situations that may occlude their attempts to get help.

The Food Issues Eating Us Alive

1. Recognize that the brain can be hardwired to crave certain foods, which is made worse by the food manufacturers who increasingly put sugar and refined carbohydrates into their products to increase cravings.
2. Assess whether overeating is fueled by avoiding certain foods because of a trigger issue or is a true addiction to those foods and how this is an important step in beginning treatment.
3. Explain how treating food addiction is a mind, body, and spirit endeavor, and that simply addressing one aspect of this problem will not help to control the triggers and cravings.
4. Demonstrate how treating the mind should involve helping clients identify the issues driving their food addiction and treating the spirit should help clients find peace and faith that they can change for the better.

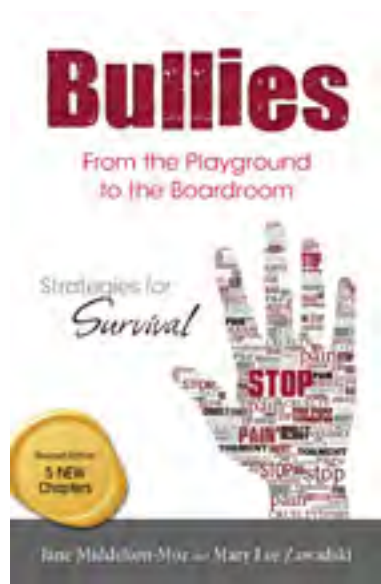
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Bullies: From the Playground to the Boardroom

Jane Middleton-Moz & Mary Lee Zawadski

Reviewed by Leah Honarbakhsh



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Just in time for National Bullying Prevention Month this October, author and speaker Jane Middleton-Moz and her colleague Mary Lee Zawadski bring bullying back into the spotlight with a revised edition of *Bullies: From the Playground to the Boardroom*. In a day and age where school shootings are on the rise, twenty million Americans face workplace abuse daily, and 160,000 American children miss school every day to avoid bullying, this edition of *Bullies* is a much-needed and timely response to the epidemic that has caused so much pain in so many people.

In *Bullies*, Middleton-Moz and Zawadski provide readers with a four-step approach to preventing the injuries to self-worth that bullying produces:

1. Break the chains of denial that have held us captive.
2. Learn not to personalize the bully's bad behavior, empower ourselves with self-awareness, and seek the support of others.
3. Learn to recognize the styles and tactics of bullies in much the same way that we would familiarize ourselves with hazard signs on our roadways and highways.
4. Learn the strategies and skills that are necessary to effectively deal with the bullies in our lives. Learn tools that will prevent us from being hemmed in and held as the bully's emotional captive.

Using these steps, Middleton-Moz and Zawadski present in-depth methods and exercises that will allow readers to tackle bullying head-on, build confidence, and stand up for themselves. Pieces of advice such as "Look the bully straight in the eye" and "Use confident body language" are meant to teach assertiveness and empowerment to those coming face-to-face with a bully. Additionally, the authors present examples and strategies for coping with a number of bullying styles, such as "Head-On Collisions," bullies who lash out seemingly out of nowhere; "Rear-Ended" bullies, who hide their bullying with sarcasm and jokes; and "The Controller" bullies, who have a distorted view of reality and an unparalleled sense of righteousness.

One of the most important and unique facets of *Bullies* is that readers have the opportunity to hear the story from the bully's side; one of the chapters features stories about bullies that provides insight into why they behaved the way they did. Nancy, who was a teenage bully, recounted how she felt fearful and unworthy, and how she was bullied by her parents throughout her childhood. Ann, who was abused and bullied by her parents, raped and threatened by someone she once thought to be a friend, and fired from her job as a result of a malicious rumor, became a bully and a "tough girl" when she thought it was "useless" to try to be good. These revelations—alongside indispensable and comprehensive information regarding early childhood development—help readers understand the makings of a bully and how most often those who bully were once victims themselves.

Bullies is a revolutionary look into the minds of bullies, victims, and those who watch from afar, as well as a workbook for what to do in the face of bullying. Middleton-Moz and Zawadski explore the inner-workings of effective bullying prevention programs in schools and bullying in adult relationships, both areas that are not tackled in every conversation about this epidemic. Additionally, the stories that are presented throughout the book allow readers to get a firsthand look at different kinds of bullies, how bullying develops, and how people can get help. *Bullies* is an essential read for the teacher, the counselor, and the parent as well as any others with the ability to foster positive change in bullies and their victims.

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"Addictions more than coexist; they interact, reinforce, and become part of one another. They become packages. The different types of addiction interaction will be discussed and presented with appropriate treatment strategies for each emphasizing effective diagnosis, assessment, and treatment for addiction interaction." –DR. PATRICK CARNES

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- NATIONAL CONFERENCE ON
Adolescents/Young Adults
Doubletree Hotel | Philadelphia, PA | October 15–17, 2014
- 2nd INTERNATIONAL CONFERENCE ON
Sex and Love Addiction
Westin Beach Resort & Spa | Ft. Lauderdale, FL
November 12–14, 2014

2015

- 36th ANNUAL TRAINING INSTITUTE ON
Behavioral Health & Addictive Disorders
Hilton Clearwater Beach Resort | Clearwater Beach, FL
February 9–12, 2015
- 7th Annual Conference on
Counseling Advances
Red Rock Resort, Spa, and Casino | Las Vegas, NV
March 19–21, 2015
- 13th NATIONAL CONFERENCE ON
Adolescents and Young Adults
Westgate Las Vegas Resort and Casino | Las Vegas, NV
April 23–25, 2015
- 2ND NATIONAL CONFERENCE ON
Trauma, Addictions & Intimacy Disorders
Doubletree Hotel Downtown | Nashville, TN
April 30–May 2, 2015
- 28th ANNUAL NORTHWEST CONFERENCE ON
Behavioral Health & Addictive Disorders
Hyatt Regency Bellevue | Seattle, WA
June 29–July 1, 2015

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